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

Meeting report

WHO/HTM/TB/2013.08

Contents

Welcome address 4
Declaration of Interests 4
Meeting objectives 4
Technical Sessions 5
Session 1: To follow up on recommendations made and action points agreed upon during the 3rd gGLC meeting 5
Session 2: To provide an update on progress and achievements of the respective rGLCs in supporting MDR-TB management scale-up 7
Session 3: To provide an update on activities and achievements under TB CARE 1 and 2 projects in supporting MDR-TB management scale-up 10
Session 4: To provide an update on work relating to i. “short” regimens for the treatment of MDR-TB and ii. Palliative care for MDR-TB cases 12
Session 5: To provide an update on new policies of the Global Fund 13
Session 6: To provide an update on WHO's new policy on case definitions and treatment outcomes 14
Session 7: To present evidence for the use of isoniazid (H) in the treatment of all MDR-TB cases 15
Session 8: To provide an update on WHO's action in relation to new TB drugs and their rational introduction 15
Session 9: To provide an update on the Global Drug Facility (GDF) and drug availability 17
Session 10: Moving forward on global support to scale-up of MDR-TB services and care 19
Annexures 22
List of Participants 23
Agenda 27

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)

EUR rGLC

The EUR rGLC was established in 2011 and has been conducting regular meetings – in person and virtual (via WebEx). The next face-to-face rGLC meeting is planned for 3-4 September 2013. An updated mission report format of rGLC-Europe has been implemented. The format is simplified with more user-friendly summary section and increased adaptability. GLC-Europe monitoring missions are often jointly organized with TGF and/or GDF. The GLC TA is also embedded in NTP review missions (e.g. to Moldova)

Key issues:

- Insufficient political commitment, outdated guidelines, weak HR planning and management, IC, insufficient patient-centeredness, rise of TB/DR-TB-HIV, access to care of vulnerable groups and demographic shifts

- Poor treatment success rate (48.8 %, target: 75%)
- Sustainability of programmes after TGF support ends, particularly in the upper-middle income countries
- Existing system of Health Services and Health Financing in Member States (i.e. heavily inpatient based)

SEAR rGLC

The SEAR rGLC was constituted in April 2012 and held two meetings in the year. The third meeting is scheduled for 29-30 April 2013. The 2nd meeting reviewed r-GLC country mission reports conducted between 1st and 2nd r-GLC meeting (Thailand, DPRK and Bhutan) and has issued guidance on roll out of newer diagnostics including GeneXpert.

Key issues:

- Limited laboratory capacity and networking
- Limited national and sub national capacity to maintain and improve quality services for DR-TB cases including insufficient human resources
- Inadequate supervision of and support to PMDT sites due to lack of sufficient human resources
- Low case detection due to weak networking and referral between PMDT services and other TB service providers
- Limited implementation of PPM
- Lack of clinical management skill and inadequate implementation of TB-IC measures
- Improved communication with country PMDT and g-GLC through r-GLC
- Recruitment of MDR-TB focal point in SEARO

WPR rGLC

After being established in 2011, the rGLC has had two face to face meetings in 2012. There also has been plenary discussion between the rGLC and the Technical Advisory Group (TAG) for WPRO. To date, 6 teleconferences have been held between rGLCs demonstrating active communication and coordination.

Key issues:

- Financial sustainability
  - TGF allocation for TB is insufficient to sustain, let alone expand, PMDT services
  - Countries are as result hesitant to scale up
  - Scale up plan depends on the resource availability
  - Smaller countries have less access to 'impact funding'
- Others
  - Alignment of diagnostic and treatment capacity.
  - Cure and defaulter rates (especially first cohorts)

Discussions and recommendations:

The participants greatly appreciated the role of the rGLCs and their respective rGLC Secretariats, and the exceptional work done by those who have now been established for over a year. The members felt the need for strengthening of all rGLCs in their capacity to scale-up PMDT in respective Regions and encouraged rGLCs to closely monitor the performance at country level. For this, the members recommended:

- To map out the current situation in relation to National Strategic Plans, available funding and unspent international funding; (rGLCs)

- To identify reasons for underutilization of in particular TGF funds in some countries, and provide on a priority country basis the necessary support for timely utilization; (rGLCs)
- to work with countries to have up to date, fully costed 3-5 year National Strategic Plans for TB control, which ensure alignment of diagnostic and PMDT treatment capacity, and include policies that ensure all MDR TB cases are detected rapidly and are subsequently promptly placed on treatment. (rGLCs, WHO and partners)
- Country specific MDR-TB targets to be considered using the most up to date epidemiological information available, along with country specific analyses of MDR-TB amongst new and previously treated cases, to monitor country performance (WHO, TBP)
- The gGLC and MDR CG recognizes that in certain country settings, the majority of MDR-TB cases exist amongst the new cases, and recommends that country specific epidemiological information should be used to decide which patients or risk groups are to be routinely tested for MDR-TB. Where appropriate, diagnostic services need to be expanded to offer routine testing for all new cases. (Countries, rGLCs, WHO)
- Global and regional advocacy efforts to be undertaken to ensure that domestic and international agencies make available the required funds to support such required expansion of diagnostic, treatment and management services (TBP, WHO, gGLC and rGLCs)
- An internal evaluation/review is urgently undertaken of the list of currently available PMDT consultant pool to enrich the pool and to inform whether further consultant trainings are required. (gGLC & rGLC Secretariats)
- Practical skills of newly trained PMDT consultants in all regions should be strengthened through mentorship activities to increase the pool of available PMDT consultants, whilst promoting in country expertise /south to south consultant collaborations. Where appropriate and available, engage with other existing mentorship programmes. (rGLC & Secretariats)

Session 3: To provide an update on activities and achievements under TB CARE 1 and 2 projects in supporting MDR-TB management scale-up

Dr Maarten van Cleeff representing the PMU of TB CARE1 presented the TBCARE's Programmatic Approach based on the same principles as the five-pronged DOTS approach. These include:

1. Political commitment and country ownership
2. Availability and access to quality assured and fast diagnostics
3. Standardized case-management and second-line drugs treatment
4. Uninterrupted supply of quality SLDs
5. Monitoring and evaluation

Dr Cleeff informed that TB CARE project countries are now making GeneXpert as the central strategy for MDR-TB diagnosis. The decentralization of Xpert networks is slow in many countries, and access is still a problem. Simpler and expanded algorithms may be necessary as access improves. However access to treatment is lagging behind diagnosis in some countries, with the resultant ethical considerations to the existence of such treatment waiting lists. The project is trying to synchronize Xpert scale-up with C/DST services scale-up, LPA and treatment services. It is also observed that community-based PMDT care is not being realized/limited, with a policy of mandatory hospitalization at the beginning of treatment remaining in some countries, which continues to act as a bottleneck for the access to treatment.

Key challenges to scale up of PMDT include:

- Mobilization of the required human and financial resources
- Increasing treatment capacity, via

  - Ambulatory treatment
  - All sectors: Hospitals, Private, army etc. sectors
- Enrolment of all diagnosed MDR-TB patients on treatment
- Increasing laboratory capacity for the diagnosis of MDR-TB
- Increasing the demand for DST by clinicians
- Strengthening the monitoring of diagnosis and treatment
- Revisiting the M&E systems; adding programmatic performance indicators

Dr Michael Rich presented status of DR-TB related activities under TB CARE 2 project. The core activities of the project include:

- PIH is the lead partner for the DR-TB Training Network (https://drtbnetwork.org/). The website has three components
  - Online Learning
  - Resources (cPMDT training material for both clinicians and DOT providers)
  - Fellowships
- Infection Control (FAST Strategy)
- Pocket Guide (coming soon)

In May 2012, there were 7 fellows trained in PMDT: 4 in Russia and 3 in Peru. In 2013 there will be 2 fellows in Lesotho and 3 in Peru. KNCV is offering the fellowship in Rwanda at the Regional Center of Excellence for PMDT funded by USAID East Africa.

The first web course in MDR-TB basics with 6 lectures was organized in July 2012. The recorded webinars and presentations are available on the site at all times. People from 69 different countries registered. There were 669 participation events with 292 unique users. In terms of events, 55% were from Asia and the next largest group, 19%, was from Africa.

In 2013, the project will offer a basic course on MDR-TB management in English and Russian and one on Paediatric DRTB management in English. The Sentinel Project on Paediatric Drug-Resistant Tuberculosis is a global partnership of researchers, caregivers, and advocates aiming to develop and deploy evidence-based strategies to prevent child deaths from this treatable disease. The Sentinel Project members create a learning network committed to generating and disseminating knowledge and data for immediate action. In 2012, the 'Management of Multidrug-Resistant Tuberculosis in Children: A Field Guide' was produced to provide information on how to organize, implement, and monitor paediatric MDR-TB infections.

FAST is a TB infection control strategy that aims to re-emphasize the administrative controls of diagnosing and placing patients on effective TB or MDR-TB treatment. FAST stands for Finding TB cases Actively, Separating safely, and Treating effectively. The FAST IEC package is a set of materials to assist healthcare workers at the facility level to visually recall and understand the FAST strategy. In this package, there are visual aids, job aids, posters, an introductory booklet, and protocol. Currently, this set of materials and associated strategy are being piloted in Zambia. FAST will be used in Bangladesh in 2013.

Country Support is being provided to Bangladesh and Malawi. The project in Bangladesh is led by URC in collaboration with PIH. PIH is responsible for most activities related to DR TB. There has been a steady increase in number of MDR-TB cases diagnosed and treated. However this is still below the targets. One of the biggest challenges facing outcome in MDR-TB services is high default rate.

Session 4: To provide an update on work relating to i. "short" regimens for the treatment of MDR-TB and ii. Palliative care for MDR-TB cases

Dr Ernesto Jaramillo, LDR Unit, STB, clarified WHO's position with regard to short regimen, namely that regimens which are markedly different from the WHO currently recommended regimens, should be used only within the context of research and under close monitoring of the clinical and bacteriological response to treatment for a period of at least 12 months after treatment is completed. One of the major concerns is that patients who do well after 9–12 months of treatment with fewer drugs in the continuation phase than in the longer regimen may have a higher risk of acquiring resistance in the process and relapsing. Proper attention to regulatory and ethical issues will be needed to facilitate gathering evidence for use in future updates of policy and standards. Until sufficient evidence is available to inform a change in policy, WHO is advising countries on a case-by-case basis to introduce short MDR-TB regimens in projects where:

- Treatment is delivered under operational research conditions following international standards (including Good Clinical Practice and safety monitoring), with the objective of assessing the effectiveness and safety of these regimens;
- The project is approved by a national ethics review committee, ahead of any patient enrolment; and
- The programmatic management of DR-TB and the corresponding research project are monitored by an independent monitoring board set up by, and reporting to, WHO.

Dr Jaramillo informed that Benin, Burundi, Cameroon, Central African Republic, Côte d'Ivoire and Niger wish to implement short regimen for MDR-TB, whilst following WHO policy. These countries have approached WHO for TA and have been supported for development of an appropriate operational research (OR) protocol. WHO is awaiting receipt of OR protocols from Bangladesh and Swaziland for review.

Palliative Care

Emphasising the need for preventing and alleviating suffering in MDR-TB patients, Dr Jaramillo, LDR Unit, STB, pointed out that MDR-TB patients suffer at the physical, emotional, social, spiritual and economic levels. Some of the reasons for preventing suffering from public health point of view include that neglect of suffering is obstacle for treatment adherence, once treatment failure is declared patients will remain a source of transmission and high risk of further amplification of resistance.

The WHO definition for Palliative care is – "Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual" (http://www.who.int/cancer/palliative/definition/en/)

Some of the earlier discussions on prevention and alleviation of suffering have led to the conclusion that palliative care should begin at the time of the diagnosis and should be considered in addition to medical treatment. The alleviation of suffering is not limited to patients who do not respond to active treatment or patients who no longer qualify for active treatment and it includes but is not limited to "end of life care". Alleviation of suffering is a must wherever quality of life matters

A non-exhaustive list of possible actions in order to mainstream holistic care that includes prevention and alleviation of suffering into PMDT are:

- Increase awareness

- Advocate to address the needs of patients and caregivers
- Secure political commitment
- Assess needs and capacity in place
- Develop research agenda and update policy-guidelines
- Address gaps in drug management
- Budget costs and mobilize resources
- Develop human resources
- Develop effective models of care, especially end-of-life care
- Build capacity for technical assistance
- Develop indicators for monitoring and evaluation

Discussions and recommendations:
The gGLC and MDR-CG strongly endorse the fundamental concept of "alleviation of suffering" or "total quality care" for all MDR-TB patients. The members feel that holistic care should be available for all MDR-TB patients from the time of diagnosis and that it is not solely limited to end of life support. The members also agree on the need for prevention and alleviation of suffering for improving quality of life and recommend:

- to enhance the palliative care component in the strategy for the programmatic management of MDR-TB care, through the proposed list of actions presented at the meeting (WHO)
- WHO and partners to develop next strategic steps for developing palliative care/ "total quality care" in PMDT, including monitoring of implementation by country programmes (WHO and technical partners)

Session 5: To provide an update on new policies of the Global Fund

Dr Eliud Wandwalo, The Global Fund presented the New Funding Model (NFM). The principles of the NFM are:

- Greater alignment with country schedules, context, and priorities
- Focus on countries with the highest disease burden and lowest ability to pay, while keeping the portfolio global
- Simplicity for both implementers and the Global Fund
- Predictability of process and financing levels
- Ability to elicit full expressions of demand and reward ambition

Key features of the NFM include: predictable funding whereby applicants are given an indicative funding range over a 3 year period; and flexibility in timing of grant as applicants can apply for funding when they want and submit different disease or health systems strengthening requests at different times. Under the NFM, the applicants will receive early feedback on the concept note from the Secretariat and the Technical Review Panel leading to possibility of higher success rates. There are provisions for "Incentive Funding" which is a performance based fund in addition to the indicative funding. The grant making process will have an upfront risk and capacity assessment process and the funding requests will be negotiated before the board approval.

There are three types of applicants in the NFM:

1. Early applicants who will receive a new grant and are eligible for indicative and incentive funding.

2. Interim applicants who receive funding through renewals and extension of existing grants, and redesigns to access funding in 2013.
3. Standard applicants who will prepare for applications to be submitted in late 2013 or in 2014.

Countries eligible for TB grants under early and interim funding under the NFM are:-
Early: Kazakhstan, Myanmar, Philippines**.**
Interim: Belarus, Nicaragua, Dominican Republic, Cambodia, Viet Nam, Bangladesh, Solomon Islands, Indonesia, Pakistan, PNG, Sri Lanka, Benin, Zimbabwe, Ethiopia, Kenya, Mozambique, South Africa, Tanzania, Zambia, Egypt.

Discussions and recommendations:
The meeting participants feel that the current allocation of financial resources by different funding agencies is far less than the envisaged need for PMDT scale-up, specifically keeping in view the 2015 global goal of universal access to PMDT care. With the new model of TGF funding coming into place, several countries will need support in preparing application to TGF for funding. Therefore the members recommend:

- Global and regional advocacy efforts to be undertaken to ensure that domestic and international agencies make available the required funds to support country plans for PMDT scale-up (TBP, WHO, gGLC and rGLCs)
- Support to early and interim applicants under Global fund to ensure that PMDT scale up is factored into the additional funds for the identified countries (rGLCs)

Session 6: To provide an update on WHO's new policy on case definitions and treatment outcomes

Dr Dennis Falzon, LDR Unit, STB, presented the WHO 2013 revision of definitions and reporting framework for tuberculosis. The product has been a result of collaborative work of WHO staff at different levels, technical partners and national staff.

The reasons for need of a revised set of definitions include:
- Bacteriological confirmation needs to consider results from new WHO-approved rapid diagnostics (WRD), including Xpert MTB/RIF.
- Patients diagnosed with rifampicin-resistant TB (RR-TB) using WRD need separate enumeration from confirmed MDR-TB cases for surveillance and monitoring.
- Simplification of definitions of "Cured" and "Treatment failed" in RR-TB cohorts to allow their application while patient is still on treatment.
- Less judgmental language: *defaulter* replaced by *Lost to follow-up* and *TB suspect* by *presumptive TB*.

Accordingly the necessity for revising reporting formats was:
- Combining outcome reporting for drug-sensitive and RR-TB for countries where programmatic management of DR-TB is incorporated (“mainstreamed”) in the NTP.
- Childhood TB reporting was incomplete because age disaggregation was previously limited to sputum smear-positive TB, which is uncommon in children.
- There was a delay of two calendar years in the reporting of co-trimoxazole preventive therapy (CPT) and antiretroviral therapy (ART) in TB/HIV because these data were collected only in the treatment outcome reports and not in the case registration reports.

Revised forms and reports for RR-TB will be discussed in greater detail in the forthcoming "Companion handbook to the 2011 WHO guidelines for the programmatic management of drug-resistant tuberculosis".

Discussions and recommendations:
The meeting participants welcome the revision of definitions and reporting formats. However the members feel that introduction of these new definitions and reporting formats in various countries needs to be via a well-coordinated and guided effort. There need to be uniform messages passed through various technical partners to avoid any confusion in implementation. Therefore the members recommend:

- Development of clear communication messages for Member States in relation to the revised case definitions, treatment outcomes and reporting framework. (WHO)
- Development of an interactive training module for the revised case definitions, treatment outcomes and reporting framework (WHO) ; and
- WHO coordinates with rGLCs and technical partners to impart in-country training required for introduction of new case definitions and treatment outcomes. (WHO, rGLCs, technical partners)

Session 7: To present evidence for the use of isoniazid (H) in the treatment of all MDR-TB cases

Dr Chen-Yuan Chiang, The Union, presented a summary review of literature on use of isoniazid in MDR-TB treatment citing evidence. A study titled 'Treatment of isoniazid- and streptomycin-resistant pulmonary tuberculosis with ethionamide, pyrazinamide, and isoniazid' by Petty et al in in 1962 showed a significantly higher treatment success rate and low rates of relapse/ failure when high dose of H was used (Petty TI, et al. Am Rev Respir Dis 1962; 86: 503–512). Another study – 'High-dose isoniazid adjuvant therapy for multidrug-resistant tuberculosis: a randomised controlled trial of' compared patients who received high-dose H with those who did not receive H (Katiyar SK, et al. Int J Tuberc Lung Dis 2008; 12: 129-45). Those patients who received high dose H became sputum negative 2.38 times (95%CI 1.45–3.91, P 0.001) more rapidly, and had a 2.37 times (95%CI 1.46–3.84, P 0.001) higher likelihood of being sputum-negative at 6 months.

Dr Chen-Yuan also presented treatment outcome of patients receiving short-course regimen in Bangladesh. In the regimen, high dose H is part of Intensive phase of MDR-TB treatment regimen. The reported outcome shows a very high treatment success rates using this regimen.

Discussions and recommendations:
The participants of the meeting unanimously agreed that there is insufficient evidence currently to recommend for or against the use of high dose H in all MDR-TB patients.

Session 8: To provide an update on WHO's action in relation to new TB drugs and their rational introduction

Dr Christian Lienhardt presented a conceptual view for the process of introduction of new drugs in countries. WHO has a key role to play for the development of policy recommendations for rational introduction and use of new drugs/regimens in programmatic settings, ensuring proper, equitable and cost-effective access to treatment.

The introduction of new anti-TB drugs in practice is a *multistage process;*

- Development of appropriate combination(s) of drugs needs efficient coordination and sharing of data between key partners;
- Introduction of new TB drugs should be adaptable to countries settings according to country's own health infrastructure and preparedness;
- Need for rapid approval of new TB drugs by regulatory authorities in high-TB burden countries so as to favour due access;
- Equitable access to new drugs to all patients in needs worldwide is essential and should be linked with measures to prevent misuse of the drugs;

The WHO approval of guidelines by a WHO Guidelines Review Committee is followed by production of information notes aimed at facilitating the production of policy recommendations for the treatment of TB (all forms), according to progress made in the development of new drugs/combinations of drugs. The Information notes are developed for countries, drug/regimen developers and regulators

The "*Policy Development Framework"* for introduction of new TB drugs/regimens in countries describes the process for development of policies for treatment of TB including the new drugs/regimens and will be used to guide development of policy recommendations for specific drugs/regimens as data become available as well as by the expert committees that will be convened by WHO to update/revise policy recommendations as needed.

Market introduction includes a map-out of the detailed expertise needed (drug market introduction, pricing, funding, public *vs.* private issues) and identify appropriate stakeholders (incl. TGF; UNITAID; GDF; CHAI, etc.) and evaluating market shortcomings and commodity access issues. This step also helps identify potential obstacles related to introduction and work with stakeholders (countries, drug developers, economists, market specialists, NGOs, donors…) to optimize market introduction.

Introduction of new drugs in countries depends on country preparedness including availability of background epidemiological data (*"know your epidemics"),* the status of Health infrastructure and the NTP structure. WHO provides country support to enable access to new drugs ensuring strengthened capacity for diagnosis, drug resistance, surveillance, pharmacovigilance. There is a need to ensure standardized definitions of outcomes to harmonize data collection after drug introduction. The drug supply and management systems need to be in place. It's also advantageous to develop *"Demonstration projects"* for initial deployment of new drugs with harmonised methods and surveillance. Community/patients' representatives contribution in introduction of new drugs cannot be ignored.

The key messages are:

- Ensure equitable access to new drugs to all patients in needs worldwide and avoid acquisition of new resistances
- Identify suitable drug combination(s) for treatment of DS and DRTB early
- Need to work on country preparedness and clarify conditions for controlled/accredited access to new drugs
- Encourage collaboration between drug developers, regulators, and programme managers
- Find the suitable balance for easy access to new therapies and guarantee patients protection with use of drugs that remain efficient and safe worldwide
- A multi-partner project: dialogue with drug/regimen developers, sponsors, regulators, National TB Programme managers.

Discussions and recommendations:
Taking into account the long procedural time for inclusion of drugs in the essential medicines list (EML) and the fact that increasing role of Group 5 drugs is now seen in treatment of MDR/XDR-TB, the members recommend that:

- The rGLCs, technical agencies and partners to share with WHO, all "grey" data on the use of Group 5 drugs in order to help generate the evidence required to get these drugs considered for inclusion in the 2015 WHO EML. (rGLCs, technical agencies and partners)

Session 9: To provide an update on the Global Drug Facility (GDF) and drug availability

Mr Joël Keravec, GDF Manager a.i. updated the meeting on current status of second line drugs (SLDs) availability and the new GDF Strategic Framework Implementation to ensure quality SLDs availability at lowest possible prices. GDF is more than a traditional procurement mechanism – rather it is a one-stop access for provision of medicines and diagnostics through:

- Emergency one year grants - bridge TB program gaps for first line drugs (FLDs)
- Grants for FLDs to continue for 1 more year to allow for proper phase-out
- Grants for SLDs: under discussion with donors
- Direct procurement (DP) – TB programme buys FLDs, SLDs, Diagnostics through GDF
- In-country technical assistance in procurement and supply chain management

All SLDs are now available through the GDF without any supply problems. In November 2012, GDF/IDA conducted a competitive bidding exercise for SLD's. Invitations to Bid were sent to all eligible manufacturers and new long term agreements are valid from 01/01/2013. The GDF has reselected IDA as procurement agent for both FLDs and SLDs.

The MDR-TB treatment supplied per annum has doubled in 2012, reaching 39,383 against a supply of 19,605 treatments supplied in 2011. GDF's pooling of SLD procurement has contributed to reducing treatment costs by 29% from 2005 to 2012, after adjusting for inflation. As 4 major SLDs contribute to 80% of a standard regimen and the costs of it (PAS products combined (sodium and acid formulations), cycloserine, kanamycin and capreomycin), it is to be noted, that while prices of kanamycin remain unchanged for 2013, price reductions were achieved for PAS products, capreomycin and, most importantly, cycloserine (-37% price reduction from current supplier Macleods, and up to 45% reduction for Lupin ERP product versus current GDF price).

GDF has significantly increased the number of suppliers. When the number of suppliers increases, total manufacturing capacities increase, also increasing competition between manufacturers, thus impacting positively prices of medicines for the entire TB community. The GDF product catalogue includes details of all the drugs that GDF procures, including price range and highest available price. For most products, GDF has multiple suppliers and cheaper prices may be available during quotation, in addition to consolidation of orders and staircase pricing. Online catalogue is available at *http://stoptb.org/gdf/drugsupply/pc2.asp*

Rationale for GDF New Strategic Future Direction

- Aims at zero tolerance for stock-outs in countries to re-shape operations
- Continue to further shape the market for more affordable prices with no compromise on the international quality standards for TB drugs
- Build on lessons learnt from the past and regular market dynamics research
- Incorporate new TB drugs and diagnostics within GDF platform

- Promote innovative tools for forecasting, M&E to countries and leverage communication/collaborative actions with partners
- Mobilize and catalyse partners expertise, including in country technical assistance programs to improve service delivery and data management
- Foster countries shared responsibility, accountability and sustainability for supply chain systems strengthening, regulatory aspects and rational use
- Work closer and focus on country needs and feedback to improve operations

Rationale for the new GDF operation model and strategy:

- Zero tolerance for TB Drugs stock-outs => pro-active actions
- Redefinition of operations based on evidences / assessment of limitations from current model and lessons learned:
    - Pbs increased + when switching from grants to DP
    - Operations too focused / dependent on financial model
    - Lack of information sharing / coordination / collaborative actions
- Build a more synergetic approach for global delivery leveraging partners competencies and in country presence

Common Challenges

- Lack of control:
    - On the way countries allocate or disburse domestic funding for TB drugs direct procurement
    - For delays from countries or PR on TGF agreements signing
    - On the PR to disburse funds
    - Unforeseen situations/out of hand forces

- At the Country level:
    - Weak data collection and misguided enrolment rates
    - Weak drug management with lack of procurement skills, stock and shelf life control
    - Weak country supply chain systems from the moment of drug deliveries
    - Irrational costs and lack of QA policies
    - Inadequate planning/drug forecast (buffer stock not included…)

- Lack of information access / information sharing or pro-active measures including:
    - Follow-up of operations & in coaching countries
    - Mentoring countries on their supply chain management and planning issues

Current model has been able to deliver well in certain settings where the mentioned challenges are more controlled, but some adjustments on the current model could give the appropriate timely response. The TGF Market Dynamics Committee acknowledges the progress done so far on this fragile yet SLDs market, and does not recommend fragmenting more this market evolving towards consolidation. Therefore independent regional stockpile may contribute to further fragment the market, and same challenges will remain if not addressed on a more coordinated way

Discussions and recommendations:
The meeting participants appreciate the work been done by GDF under the current leadership to bring down the prices and ensure regular supply of quality assured SLDs. The members also feel that there is a need for continued efforts to bring down prices of some of the drugs that are still out-of-reach in resource constrained setting.

The gGLC and MDR CG strongly support the new operating model of GDF, including the proposed expanded global FLD and SLD stockpile, flexible procurement fund, continued price negotiations, and increasing the pool of pre-qualified suppliers. (TBP/GDF)

Whilst the GLC and CG recognises the significant decreases achieved to date by GDF in the cost of a SLD treatment course, the meeting recommends:

- Continued work and advocacy is needed, including the engagement of communities and broader constituencies, in order to achieve further price reductions in SLDs. (TBP/GDF, WHO, gGLC & rGLCs)

Session 10: Moving forward on global support to scale-up of MDR-TB services and care

Dr Aamir Khan, Chair of the MDR-TB Working Group, reminded the meeting that there is an on-going discussion within the TBP in relation to the role and structure of the WGs and their respective sub-groups. He presented the existing structures of the MDR-TB Working Group, gGLC and their respective functions. In its current form, the MDR-TB WG functions as a platform to bring partners together to advocate for PMDT scale-up and help implement MDR-TB strategies, while the gGLC acts as a technical advisory body to both the WHO and the MDR-TB Working Group. The broader roles of MDR-TB WG are:

- Country advocacy: Advocates for accelerating scale-up of MDR-TB diagnosis and treatment based upon analysis of country and global level data by engaging patients, other NGOs, HCWs, and stakeholders within countries
- Activist role: Provides mechanism for intensive collaboration with partners on mainstreaming PMDT in to national TB control programs linked to rGLC technical support
- Convening, coordinating and championing role: Acts as a multi-partner, multi-disciplinary platform to foster effective, coordinated actions to build programmatic management of drug resistant TB (PMDT) capacity worldwide

The relationship between MDR-TB WG and gGLC is described in the New Global Framework that was created after 20 month process that was endorsed by the TBP Coordinating Board in April 2011 and the WHO TB STAG in June 2011.

Dr Amy Bloom, Interim Chair, TBP Coordinating Board, added more details on the on-going discussions within the TBP on the role and structure of the WGs and their respective sub-groups. This topic was discussed at the meeting of the TBP's Executive Committee in Seattle, in March 2013, with further discussions and decisions needed in advance of the next TBP Board Meeting in July 2013.

It is felt that the MDR-TB WG, along with its sub-groups, needs to be restructured to provide a boost to PMDT scale-up globally. A need is also felt to streamline the activities of the MDR-TB WG along with those of the gGLC in order to remove any actual or perceived overlaps and redundancies. The overall message is however that *form should follow function*.

A strengthened focus on the support to countries for scale up of PMDT services was at the core of the New Global Support Framework, and was the consensus of the "Moving Forward with MDR-TB scale-up" meeting held in June 2012. The ideas generated during the June 2012 meeting were taken forward to the "Stakeholders Meeting on Scaling up MDR-TB Care Delivery" in Kuala Lumpur, November 2012.

Dr Fuad Mirzayev, LDR Unit, STB, updated the meeting on the 7th meeting of the MDR-TB WG held from 11 to 12 November 2012 in Kuala Lumpur, Malaysia. Close to 140 participants representing multiple stakeholders participated in the meeting. Key topics discussed during the meeting were:

- Treatment capacity, keeping pace with demand induced by innovation and scale up of TB diagnosis;
- Innovative models of technical assistance and HR development to facilitate and support countries expanding their treatment capacity;
- Catalysing civil society involvement and support;
- MDR-TB supply chain priority actions in the current plans for scale-up.

Highlights from the discussions at the Kuala Lumpur meeting included:

- Countries need support in scaling up MDR-TB management
- The gap between diagnosed and enrolled on treatment DR patients remains and may grow with improving access to diagnostics
- Coordination of partners and focusing efforts at country level is important task
- MDR-TB WG can leverage in the weight of international community to assist country programs and support scale-up in countries through focused interventions in selected countries
- Reliable and robust criteria need to be developed to allow transparent selection of several countries that will benefit from the MDR-TB WG support

The main decisions and outcomes of the Kuala Lumpur meeting were:

- Rotation of the Core Group members and election of the Chair of the MDR-TB WG to be organized in the first half of 2013.
- Stronger civil society representation to be sought for representation in the core group of the Working Group on MDR-TB.
- Communication to members of the working group to be improved using web-based tools and regular email updates.
- Core group to develop a plan for targeted interventions in selected (using pre-defined balanced criteria set) countries to facilitate faster scale-up.
- Partners are to be identified and a pilot initiated.
- Next Steps
- Develop new TORs for MDR-TB WG Core Group
- Election of new Core Group members
- Development of a pilot targeted intervention to help countries scale-up

The above needs to be recognised as part of the on-going discussions within the TBP in relation to the role and structure of the Working Groups and their respective sub-groups, and will feed into the further discussions and decisions that will be need to be made prior to the next meeting of the TBP's Coordinating Board in July 2013.

Dr Karin Weyer, LDR Unit, STB, presented the Global Laboratory Initiative (GLI) model as an option for the meeting to consider in its discussion on a new restructured MDR-TB WG. The GLI is a network of international partners dedicated to accelerating and expanding access to quality assured laboratory services in response to the diagnostic challenges of TB, notably HIV-associated and drug-resistant TB. The GLI provides a focus for TB within the framework of a multi-faceted yet integrated approach to laboratory capacity strengthening. Organizationally, the GLI is one of seven main Working Groups of the TBP, with the GLI secretariat provided by WHO HQ in Geneva. Functionally, the GLI serves as an independent, technical expert advisory group to WHO, the TBP, development agencies and countries. Structurally, the GLI consists of individuals with expertise in multiple

disciplines, representing constituencies of stakeholders and/or institutions involved in global, regional and country-level laboratory strengthening.

Discussions and recommendations:
The gGLC and CG members unanimously and strongly endorse the gGLC and MDR-TB WG Secretariats to proceed with the preparation of a draft concept document, laying out the terms of reference, operating procedures and election process for a new body based on the Global Laboratory Initiative (GLI) model that will potentially replace the existing gGLC and Core Group of the MDR-TB WG. The gGLC and CG members recommend that:

- In the interim, the existing members of the gGLC and the WG's CG will continue in position in the respective body in accordance with the bye-laws, until the new body is constituted.

The gGLC and MDR-CG request that:

- The draft concept document is shared with the gGLC and CG members within 4 weeks for their timely comment, with the aim of a final draft of the document being available for presentation and discussion at the TBP Executive Committee during the second half of May 2013. (gGLC and MDR TB WG Secretariats)

The gGLC and MDR-CG acknowledge the achievements of the decentralized MDR-TB support framework, and recommend that:

- the rGLCs continue functioning, and retain their current roles and responsibilities.

Annexures

List of Participants

Joint meeting of the gGLC and the Core Group of the MDR-TB Working Group

WHO/HQ Switzerland, Geneva

18 to 19 April 2013

gGLC Members

1. **Lucy Chesire**
   Executive Director
   TB ACTION Group
   Ambassador Court, Block A 5
   50358-00100
   Nairobi
   KENYA

2. **Chen-Yuan Chiang**
   Director
   Department of Lung Health and NCDs
   International Union Against Tuberculosis
   and Lung disease (IUATLD)
   68, bd Saint-Michel
   75006 Paris
   FRANCE

3. **Daniela Maria Cirillo**
   Head, Emerging Bacterial Pathogens Unit
   San Raffaele del Monte Tabor Foundation
   San Raffaele Scientific Institute
   A4 Dibit 2, Via Olgettina 60
   20132 - Milano
   ITALY

4. **Charles Daley**
   Division of Mycobacterial and Respiratory
   Infections
   National Jewish Medical and Research Center
   1400 Jackson Street
   Denver, CO 80206
   UNITED STATES OF AMERICA

5. **Essam Elmoghazy**
   Chair, EMR rGLC
   National TB Programme,
   Heliopolis, Cairo
   EGYPT

6. **Aamir Khan**
   Chair MDR-TB Working Group /
   Representative of EMR rGLC
   Director, MDR-TB Control Program
   The Indus Hospital
   Korangi Crossing
   75190 - Karachi

PAKISTAN

7. **José Caminero Luna**
   Consultant
   IUATLD Servicio de Neumologia
   Hospital de Gran Canaria "Dr Negrin"
   Barranco de la Ballena s/n
   35020 - Las Palmas de Gran Canaria
   SPAIN

8. **Andrey Olegorich Maryandyshev**
   Chair, GLC\Europe
   Head of the Phthisiopulmonology Department
   Northern State Medical University,
   Troitsky 51,
   163061 - Arkhangelsk
   RUSSIAN FEDERATION

9. **Domingo J Palmero**
   Chair, AMR rGLC
   Hospital Muñiz
   Nicolas Videla 559
   Buenos Aires
   ARGENTINA

10. **Michael Rich**
    Instructor & Associate Clinician
    Division of Global Health Equity
    Brigham & Women's Hospital and Harvard
    Medical School
    641 Huntington Ave., 4th Floor
    Boston, MA 02115
    UNITED STATES OF AMERICA

11. **Lee B. Reichman**
    Chair, WPR rGLC
    Executive Director
    New Jersey Medical School Global Tuberculosis Institute (UMDNJ)
    PO Box 1709, 225, Warren Street
    07101-1709 - Newark, NJ
    UNITED STATES OF AMERICA

12. **Rohit Sarin (Unable to attend)**
    Chair, SEAR rGLC
    Director,
    LRS Institute of TB and Respiratory Diseases,
    Sri Aurobindo Marg, Near Qutub Minar
    New Delhi 110030
    INDIA

13. **Hind Satti**
    Clinical Director, Partners In Health
    Corner of Lancers and Caldwell Street
    Maseru West, Maseru 100

LESOTHO

MDR-TB Working Group Core Group

14. **Amy Bloom**
US Agency for International Development
GH/OHIV/TLRD5.10.45, 5th Floor, RRB
1300 Pennsylvania Ave
Washington, DC
UNITED STATES OF AMERICA

15. **Patrizia Carlevaro (Unable to attend)**
Managing Director, Otsuka SA
Rue du Marché 3
1204 Geneva
SWITZERLAND

16. **Paula Fujiwara**
IUATLD
1188 Franklin St, Suite 203
San Francisco CA
UNITED STATES OF AMERICA

17. **Salmaan Keshavjee**
Department of Social Medicine and Medicine,
Harvard Medical School
Senior TB Specialist, Partners In Health
641 Huntington Avenue, Boston MA
UNITED STATES OF AMERICA

18. **Carole Mitnick**
Department of Social Medicine
Harvard Medical School
643 Huntington Avenue, 3rd floor
Boston MA
UNITED STATES OF AMERICA

19. **Catharina Lambregts van Weezenbeek**
Regional Adviser, Tuberculosis
WHO Regional Office for the Western Pacific Manila
THE PHILIPPINES

Others

20. **Maarten van Cleeff** (19 April 2013 only)
KNCV Tuberculosis Foundation
Parkstraat 17
The Hague
2514 JD
THE NETHERLANDS

21. **Eliud Wandwalo**
The Global Fund to Fight AIDS, Tuberculosis and Malaria (TGF)
Chemin de Blandonnet, 8

1214 Vernier
Geneva
SWITZERLAND

WHO Staff

22. **Samiha Baghdadi,** rGLC Secretariat, WHO EMRO Cairo
23. **Vineet Bhatia,** STB/LDR, WHO Geneva
24. **Martin van den Boom,** rGLC Secretariat, WHO EURO Copenhagen
25. **Dennis Falzon,** STB/LDR, WHO Geneva
26. **Tauhidul Islam,** rGLC Secretariat, WHO WPRO Manila
27. **Ernesto Jaramillo**, STB/LDR, WHO Geneva
28. **Daniel Kibuga,** rGLC Secretariat, WHO AFRO Brazzaville
29. **Christian Lienhardt,** STB/PSI, WHO Geneva
30. **Fuad Mirzayev,** STB/LDR, WHO Geneva
31. **Mario Raviglione,** Director, STB, WHO Geneva
32. **Kwang Rim,** rGLC Secretariat, WHO SEARO Delhi
33. **Fraser Wares,** STB/LDR, WHO Geneva
34. **Karin Weyer,** Coordinator, STB/LDR, WHO Geneva
35. **Anna Volz,** rGLC Secretariat, WHO AMRO Washington DC

Stop TB Partnership Staff

36. **Lucica Ditiu,** Executive Secretary
37. **Joel Keravec,** Manager, GDF
38. **Kaspars Lunte,** Team Leader, MDR–TB supply, GDF

UNITAID Staff

39. **Yamuna Mundade**, Technical Officer

Agenda

Day 1 (18 April 2013)
WHO/HQ Switzerland, Geneva – D4 6025
Chair: C Daley

09.00 – 09.15	Welcome Declarations of Interest Meeting objectives	M Raviglione, L Ditiu, A Khan gGLC Secretariat (VB) STB/LDR (KW)
Session 1 09.15 – 09.45	Objective: To follow up on recommendations made and action points agreed upon during the 3rd gGLC meeting • Report from the gGLC Secretariat • Global progress in MDR TB scale up	 gGLC Secretariat (FW) STB/LDR (DF)
Session 2 09.45 – 10.30	Objective: To provide an update on progress and achievements of the respective rGLCs in supporting MDR-TB management scale-up • AFR, AMR, EMR, EUR	 *rGLC Chairs*: AFR (DK), AMR (DP), EMR (EE), EUR (AM)
10.30 – 11.00 Coffee		
Session 2 ctd 11.00 – 11.45	Objective: To provide an update on progress and achievements of the respective rGLCs in supporting MDR-TB management scale-up • SEAR and WPR Discussions	 *rGLC Chairs*: SEA (RK), WPR (LR) ALL

Session 3 11.45 – 12.15	Objective: To provide an update on activities and achievements under TB CARE 1 and 2 projects in supporting MDR TB management scale-up • TB CARE 1 and 2 Discussions	 MvC / MR ALL
Session 4 12.15 – 13.00	Objective: To provide an update on work relating to i. palliative care for MDR-TB cases and ii. "short" regimens for the treatment of MDR-TB • Palliative care for MDR-TB cases • "Short" regimens for the treatment of MDR-TB Discussions	 STB/LDR (EJ) ALL
13.00 - 14.00 Lunch		
Session 5 14.00 – 14.30	Objective: To provide an update on new policies of the Global Fund • New Funding Model of the Global Fund (TGF) Discussions	 TGF (AM) ALL
Session 6 14.30 – 15.00	Objective: To provide an update on WHO's new policy on case definitions and treatment outcomes • New case definitions and treatment outcomes Discussions	 STB/LDR (DF)

Session 7	Objective: To present evidence for the use of isoniazid in the treatment of all MDR-TB cases	

15.00 – 15.30	• Use of isoniazid in MDR–TB treatment Discussions	CYC ALL
15.30 – 16.00 Coffee		
Session 8 16.00 – 17.00	Objective: To provide an update on WHO's action in relation to new TB drugs and their rational introduction • New drugs and their rational introduction Discussions	STB/PSI (CL) ALL
17.00 – 18.00	Wrap up of Day 1	Chair (CD)

18.00 – 19.00 Meeting of WHO HQ and Regional staff (closed meeting)

Day 2 (19 April 2013)

WHO/HQ Switzerland, Geneva – D4 6031

Chair: C Daley

Session 9 09.00 – 10.30	Objective: To provide an update on the Global Drug Facility (GDF) and drug availability • Update on GDF, availability of SLDs & Group 5 drugs Discussions	GDF (JK) ALL
10.30 - 11.00 Coffee		

Session 10 11.00 – 13.00	**Co-Chairs: C Daley & A Khan** Moving forward on global support to scale-up of MDR-TB services and care • Feedback from TBP Co-Ordinating and Executive Committee meetings on evaluation of Working Groups and their sub-groups • Feedback from KL MDR TB WG meeting, Nov 2012 Discussions	AB MDR-TB WG Secretariat (FM) ALL
13.00 – 14.00 Lunch		
Session 10 ctd 14.00 – 15.30	Discussions continued	ALL
15.30 – 16.00 Coffee		
Session 10 ctd 16.00 - 17.30	Discussions continued	ALL
17.30 -18.00	Wrap up and other business	Chair (CD)

KW	Karin Weyer	VB	Vineet Bhatia
FW	Fraser Wares	DF	Dennis Falzon
DK	Daniel Kibuga (for AFR rGLC)	DP	Domingo Palmero
EE	Essam Elmoghazy	AM	Andrey Maryandshev
RK	Rim Kwang (for SEAR rGLC Chair)	LR	Lee Reichman
MvC	Maarten van Cleeff	MR	Michael Rich
EJ	Ernesto Jaramillo	TGF	Abigail Moreland
CYC	Chen-Yuan Chiang	CL	Christian Lienhardt
CD	Charles Daley	JK	Joel Keravec
AB	Amy Bloom	FM	Fuad Mirzayev