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

WHO headquarters, Geneva, Switzerland
9–10 April 2008

WHO/HTM/TB/2008.403

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Contents

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 MDR-TB ever recorded. Revision of the methods should be undertaken; a meeting is planned for this purpose in mid-September 2008. Operational research components need to be included in routine surveys.

The findings and lessons learnt from the XDR-TB outbreak in KwaZulu Natal were presented to the meeting by the South African authorities. The MDR-TB epidemic in Tugela Ferry is unique – no similar districts elsewhere in the province have evidenced as many XDR-TB cases. The King George V hospital was found not to be a spreader

[1] WHO/IUATLD Global Project on Antituberculosis Drug Resistance Surveillance. *Antituberculosis drug resistance in the world. Fourth global report*. Geneva, World Health Organization, 2008 (WHO/HTM/TB/2008.394; available at http://www.who.int/tb/publications/2008/drs_report4_26feb08.pdf; accessed June 2008).

of XDR-TB in the province. The cause of the outbreak was concluded to be a major nosocomial spread with insufficient attention to infection control measures in the past.

Successful implementation of a line-probe assay was reported in two large public-health laboratories in South Africa. Although these tests involve high sensitivity and specificity, including some discrepancies of phenotypic DST, especially isoniazid, the assay tested in South Africa produced a higher proportion of valid results than MGIT culture in combination with DST. Equivalent performance was observed from sputum and culture; however, this assay costs less than MGIT + DST (rifampicin) in South Africa.

The expert committee considers that there is sufficient general evidence to justify a recommendation of the use of line-probe assays for rapid screening for MDR-TB management within country-specific settings. Further operational research is needed to address country-specific needs. Further discussion and recommendations on line-probe assays for rapid screening will be relayed to the WHO Strategic and Technical Advisory Group on Tuberculosis (STAG-TB).

Growing awareness of DR-TB among people living with HIV (PLWH) has been observed in the response of the HIV community to XDR-TB. Better surveillance data are needed to show the link between HIV and DR-TB epidemiology. The co-epidemic is exacerbated by XDR-TB, and fear and stigma are becoming dominant issues, with cases of incarceration with isolation, breach of confidentiality, vulnerability and risks of congregate settings.

The experience of Lesotho in addressing MDR-TB/HIV demonstrates that MDR-TB can be managed in very difficult circumstances. The challenges that the country faces include limited capacity for diagnosis of TB and MDR-TB in patients with HIV, limited availability of facilities to treat very sick patients, high risk of TB infection in settings with high HIV prevalence; delivery of MDR-TB care in urban and rural areas, shortage of trained human resource, extreme poverty (crises in food, housing and transportation) and migration of workers to South African mines.

The Swaziland perspective on ethical and legal challenges in MDR-TB treatment shows that there is a dilemma in offering therapy to patients who seem unlikely to adhere to the regimen. In situations of limited supplies, there is always a dilemma in who should have access to second-line therapy. It is further unclear if a health worker is ethically or legally obliged to put his or her life at risk while treating XDR-TB cases where facilities for application of universal precautions do not exist. Analysis of these legal and ethical challenges in addressing MDR-TB and XDR-TB call for assistance from WHO to countries on implementation of a patient-centred care approach to TB, and guidance on how to manage last-resort options such a quarantine and coercive treatment.

An update on the WHO guidelines for the programmatic management of DR-TB was presented at the meeting. The major changes compared with the 2006 version include defining case-finding strategies among PLWH, laboratory issues, treatment strategies with particular attention to treatment of XDR-TB and delivery of treatment. Community-based MDR-TB is presented as a perfectly valid option for management of MDR-TB patients. The full revision of the guidelines is scheduled for 2010.

Session 3 Accelerating scale up of the response to MDR-TB and XDR-TB

The capacity of TB laboratories should be increased worldwide in order to make serious progress in the response to MDR-TB. The Global Laboratory Initiative and partnerships built around it are making strides in this direction. New molecular diagnostic tests need to be assessed, and policy for implementation should be agreed. It was felt that more attention is also required to develop and disseminate new specifications, biosafety norms and standards. The human resource crisis in laboratories has to be addressed through human resources development both for laboratory staff and for consultants.

The global response to MDR-TB can be strengthened by fostering the involvement of all health-care providers, especially those in the private sector. The first suggested step is the creation of a task force under the Stop TB Working Group on MDR-TB in collaboration with the public–private mix (PPM) subgroup of the DOTS Expansion Working Group (DEWG).

The concept of regional centres of excellence on MDR-TB management was presented by the chair of the GLC. Participants felt that the Working Group on MDR-TB should proceed with its work, which will facilitate the training of human resources. It was suggested to develop a model based on a framework that comprises criteria, terms of reference and curricula. The Working Group should establish a task force to develop this framework, and the concept of "country scale up teams", through engaging partners and benefiting from new knowledge and information-sharing approaches and technologies. All these efforts should include civil society participation.

The Drug Management Subgroup of the Working Group and the GDF have made important progress in addressing the global SLD crisis declared in Tbilisi (2007) at the sixth meeting of the Working Group, but major challenges still remain. More efforts and manpower are needed within the GDF and with relevant partners such as the WHO prequalification project in order to: (i) produce accurate short- and long-term estimates; (ii) increase the number of suppliers; and (iii) meet the needs of countries (both within and outside GLC programmes). The Working Group should prioritize drug management and apply political pressure on countries to highlight the importance of high-quality SLDs, but also to accelerate the prequalification or other pathways for quality assurance. The magnitude of the scale of SLDs in the private retail market should be assessed and country-specific interventions pursued to restrict it.

Countries should receive assistance for the development of national plans to address the challenges of MDR-TB and XDR-TB using innovative methods such as the needs assessment tool (prepared and presented by the Program for Appropriate Technology in Health (PATH) with the help of WHO, USAID and the GLC).

Scaling up infection control measures should be introduced into TB control through the successful work of the infection control subgroup, development of guidance documents, training materials and courses.

Session 4 Mobilizing resources for universal access to MDR-TB diagnosis and treatment by 2015

The number of patients that countries plan to treat and the amount of funding available fall far short of the targets set in the Global MDR-TB and XDR-TB Response Plan 2007–2008. Since these targets have not been entirely agreed upon by countries, countries do not necessarily "own" these targets. In order to mobilize resources to scale-up management of MDR-TB, it was considered important that countries should be engaged more actively in order to increase the level of national political commitment. It was suggested to bring 27 high MDR-TB burden countries (HBCs) together for a high-level meeting.

Important strategic alliances should be built at regional and local levels to allow a fast, adequate and efficient strategy to confront the current and future situation of TB (including XDR-TB). Continuity of TB control activities at all levels of the health system needs to be guaranteed through facilitating interaction between sectors, institutions, civil society and organizations of people affected by TB.

Advocacy should be intensified to promote harmonization between all political actors, and more advocacy work was needed with donor partners, e.g. UNITAID and the Global Fund, which already provide substantial support. The importance of corporate sector engagement was demonstrated by the "Lend me a hand initiative" in Peru.

Civil society leadership is vital in creating demand and developing effective strategies to address MDR-TB. This requires their full engagement not only in trainings and treatment completion but also in policy, research and resource advocacy. Further work should be carried out with the media to frame and address community concerns of DR-TB and to highlight the challenges faced by MDR-TB patients. Guidelines and tools to address DR-TB ethical issues need to be continuously updated.

Strong political and local-level leadership are needed to develop national-level plans that include IC, laboratory strengthening, decentralization, community-based treatment, access to SLDs and preventing their misuse. Partnership between the WHO Stop TB Partnership and NTPs has to be strengthened to devise a coherent plan in order to boost national mobilization. NTP strategic plans should have MDR-TB prevention and control elements integrated, with clearly identified costs and action plans.

The meeting noted that the support of the international donor community was essential for addressing the needs for development of effective MDR-TB and XDR TB research tools as well as for conducting operational research projects on DR-TB mobilization in HBCs. Interactions from the donor organizations showed strong support to GLI, accelerated diagnostic activities, strong focus on infection control and activities from the 3Is meeting. They also showed general support for expansion and scale-up efforts in their work focus.

Session 5 Recommendations

Session 5 was devoted to concentrated feedback from the chairs of individual sessions on the presentations and discussion held in their respective sessions. Participants entrusted the WHO Secretariat with summarizing this feedback in the form of recommendations, indicating the major responsible parties for implementation of each recommendation. The following eight recommendations were distributed to, and endorsed by, all participants at the meeting:

1. Strengthen basic activities to control TB and HIV/AIDS, as detailed in the Stop TB Strategy and the Global Plan to Stop TB 2006–2015, to avoid the additional emergence of MDR-TB and XDR-TB

a. WHO and the Stop TB Partnership to convene a meeting of the 27 high-priority MDR-TB countries to increase political commitment at the highest national level, assess progress achieved in these countries and agree on actions to tackle the main factors hampering progress;

b. Countries to incorporate prisons in all reviews of TB control programmes, and WHO to promote high-level engagement of the Ministry of Health and the competent authorities responsible for health in prisons;

c. WHO to develop clear policies and usable recommendations in the following areas:

i. tools for screening TB in people living with HIV;
ii. interaction between SLDs and antiretrovirals.

2. Scale-up the programmatic management of MDR-TB and XDR-TB to reach the targets set forth in the Global Plan

a. WHO, the Stop TB Partnership and countries to engage all health-care providers in the response to MDR-TB and XDR-TB by:

i. establishing a task force on "all health-care providers" to address MDR-TB;
ii. assessing the magnitude of the unregulated market of SLDs;
iii. addressing "perverse" incentives in the private sector;
iv. ensuring that all health-care providers manage MDR-TB according to WHO guidelines for the programmatic management of DR-TB.

b. Global Fund to support proposals to involve all health-care providers in the response to MDR-TB and XDR-TB;

c. WHO to publish a fully revised version of the *Guidelines for the programmatic management of drug-resistant tuberculosis* by 2010;

d. WHO to produce and disseminate practical guidance on ethical and legal issues to support patient-centred TB care, including community-based MDR-TB care (strongly recommended in the updated WHO guidelines); MDR-TB Working Group to set up a subgroup on patient-centred care to promote the implementation of these guidelines and their further development;

e. Countries to strengthen the response to MDR-TB and XDR-TB in prisons;

f. Stop TB Partnership Working Group on DOTS Expansion to include MDR-TB in its subgroup's scope of work on "TB in children" and assist countries in addressing the needs of this specific population;

g. Countries to ensure that training on the management of MDR-TB and XDR-TB is delivered at all levels, in all areas and at levels of key importance (laboratory, infection control, health-care providers, community-based MDR-TB care, drug management);

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

i. Stop TB Partnership Working Group on MDR-TB to develop further the framework of Centres of Excellence and the concept of "country scale-up teams", with clear participation of civil society and in close coordination with the countries and programmes that the centre intends to support;

j. GDF and subgroup on drug management of the Working Group on MDR-TB to continue strengthening leadership in the management of SLDs and pursue an increase in the number of staff assigned to this task;

k. WHO, Stop TB Partnership and countries to prioritize the documentation of, and improvement in, the quality of first-line antituberculosis drugs and SLDs, as an essential measure to prevent the creation or amplification of DR-TB.

3. Strengthen laboratory services for adequate and timely diagnosis of MDR-TB and XDR-TB

a. WHO and the Stop TB Partnership to consider integration of their laboratory activities with other initiatives (HIV, polymerase chain reaction-based), and to involve private laboratories in the plan of the Global Laboratory Initiative;

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

c. Global Laboratory Initiative to provide clear recommendations on biosafety, including proper safeguards for laboratory workers infected with HIV, and subsequent training;

d. WHO to issue guidance for external quality assurance of culture and to document scaling up of external quality assurance for DST in at least all high-priority MDR-TB countries;

e. Countries to ensure active participation of TB laboratories in TB clinical trials as a partner;

f. Countries to address crisis of human resources in laboratories with measures including training both for laboratory staff and consultants.

4. Expand surveillance of MDR-TB and XDR-TB to better understand the magnitude of and trends in drug resistance and the links with HIV

a. WHO to revise tools and methods of its drug resistance survey to facilitate expansion and determination of trends;

b. WHO and countries to strengthen surveillance systems to determine more clearly the link between epidemiology of HIV and drug-resistant TB;

c. African countries to increase efforts to conduct DST.

5. Foster sound infection control practices to avoid transmission of MDR-TB and XDR-TB, and protect patients, health workers, others working in congregate settings as well as the broader community, especially in settings with high HIV prevalence

a. WHO, Stop TB Partnership and countries to conduct a systematic review of existing knowledge and promote research in infection control, evaluation of impact of ultraviolet lamps, and evaluation of pilot projects on home isolation, with the support of donors;

b. Subgroup on infection control of the Working Group on TB/HIV to develop simple guidance on infection control based on best current practice for urgent dissemination to countries;

c. WHO to integrate TB infection control into other disease infection control efforts and other initiatives (e.g. natural ventilation);

d. Countries to promote community education on TB infection control and step up measures to prevent nosocomial transmission of TB, especially drug-resistant TB.

6. Strengthen advocacy, communication and social mobilization for sustained political commitment and a patient-centred approach to treatment

a. WHO and the Stop TB Partnership to strengthen links with the media to frame and address concerns of the community about drug-resistant TB;

b. Stop TB Partnership to strengthen national partnerships to promote more comprehensive plans for TB control, boost national mobilization and consolidate ownership of the Global Plan;

c. Stop TB Partnership to promote further engagement of civil society to create more demand for changes in country policy and research for MDR and XDR-TB.

7. Pursue resource mobilization at global, regional and country levels to ensure that necessary resources are available

a. High-priority MDR-TB countries to integrate prevention and control of drug-resistant TB into revised strategic plans of national TB control programmes (with clearly identified costs and action plans for each objective of the Global MDR-TB and XDR-TB response plan) with the support of WHO and the Stop TB Partnership.

8. Promote research and development into new drugs, diagnostic tools and vaccines, and conduct operational research on the management of MDR-TB to shorten the length of treatment

a. Stop TB Partnership and key partners such as FIND and the TB Alliance to accelerate efforts for research into and development of effective tools to prevent and treat MDR-TB and XDR-TB;

b. WHO and countries to include operational research components in routine surveys on drug resistance;

c. WHO, Stop TB Partnership and countries to conduct operational research to develop and evaluate novel care-delivery model for MDR-TB and XDR-TB, especially for high HIV-prevalent settings.

2nd meeting of the WHO Task Force on XDR-TB

WHO Headquarters, Geneva, Switzerland, 9-10 April 2008
Kofi Annan Conference Room, UNAIDS-WHO Building

World Health Organization

The purpose of this meeting is to bring together a group of TB experts and representatives of member states to review the progress in implementing the recommendations of the previous XDR-TB Task Force Meeting (Geneva, 10-11 October 2006), to assess the progress of the implementation of the Global MDR-TB and XDR-TB Response Plan 2007-2008, and agree on steps to accelerate its implementation. Specifically, at the meeting participants will:

- Review the current status of TB control and anti-tuberculosis drug resistance in the world in 2008;
- Examine ways to scale-up the use of new technologies and tools in the field of MDR-TB management, through implementation of the newly updated WHO Guidelines on the programmatic management of drug resistant TB and the Global Plan to Stop TB 2006-2015;
- Discuss the barriers for scaling-up of the MDR-TB and XDR-TB response, including bottlenecks in human resources management, laboratory capacity, drug management, financial resources and political commitment, and getting broad agreement on how to address these issues over the following two years.

Wednesday, 9 April 2008		
08:30 - 09:00	Registration	
09:00 - 09:15	Opening of the meeting	Dr Hiroki Nakatani, Assistant Director General of WHO M. Raviglione, Director, Stop TB Department, WHO
session 1	**Assessing progress** *Chair: Wang Xie Siu (China)* *Rapporteurs: Abigail Wright / Matteo Zignol, WHO*	
09:15 - 09:30	Progress in implementing global response to MDR-TB and XDR-TB	Paul Nunn, WHO
09:30 - 09:40	Questions/Answers and Discussion	
09:40 - 09:55	Developing training modules to manage MDR-TB	Thelma Tupasi, the Philippines
09:55 - 10:05	Q/A and D	
10:05 - 10:20	Expanding quality assurance for TB culture and drug susceptibility testing in the Russian Federation	Marina Shulgina, Russia
10:20 - 10:30	Q/A and D	
10:30 - 10:45	Coffee Break	
10:45 - 11:00	Integrating infection control into MDR-TB and XDR-TB management in South Africa	Yogan Pillay, South Africa
11:00 - 11:10	Q/A and D	
11:10 - 11:25	Update on new drugs for TB	Christo van Nierkerk, TB Alliance
11:25 - 11:35	Q/A and D	

11:35 - 11:50	Universal access to diagnosis and treatment of MDR-TB and XDR-TB in Peru	Cesar Bonilla, Peru
11:50 - 12:00	Q/A and D	
12:00 - 12:15	Gaps at national level and needs to scale up MDR and XDR-TB response	Ernesto Jaramillo, WHO Kitty Lambregts, WG MDR-TB
12:15 - 12:25	Q/A and D	
12:25 - 13:25	Lunch	

session 2 — New evidence, updated guidelines

Chair: Refiloe Matji (South Africa)

Rapporteurs: Matteo Zignol / Abigail Wright, WHO

13:25- 13:40	Anti-Tuberculosis Drug Resistance IV Report: findings and challenges for next surveys	Abigail Wright, WHO
13:40 - 13:55	Q/A and D	
13:55 - 14:10	Kwa-Zulu Natal: lessons learned from the XDR-TB outbreak	Sipho Buthelezi, South Africa
14:10 - 14:20	Q/A and D	
14:20 - 14:30 14:30 - 14:45	FIND Demonstration Studies of MTBDR-plus Assay Molecular tests for MDR-TB management	Richard O'Brien, FIND Francis Drobniewski, UK
14:45 - 14:55	Q/A and D	
14:55 - 15:10	HIV community response to the XDR-TB threat	Charles Gilks, HIV Department, WHO
15:10 - 15:25	Addressing MDR-TB/HIV Co-Infection in Lesotho	Llang Maama-Maime, Lesotho / Hind Satti, Partners In Health
15:25 - 15:35	Q/A and D	
15:35 - 15:50	Coffee Break	
15:50 - 16:05	MDR-TB and XDR-TB management: the legal and ethical challenge	Geneviève Pinet, WHO
16:05 - 16:20	The Swaziland perspective on the legal and ethical challenge of managing MDR-TB	Themba Dlamini, Swaziland
16:20 - 16:30	Q/A and D	
16:30- 16:45	Guidelines for the programmatic management of DR-TB: emergency update 2008	Michael Rich, Partners In Health
16:45 - 16:55	Q/A and D	
18:00 - 19:00	Cocktail reception in the D Building cafeteria	

Thursday, 10 April 2008

session 3 — How to accelerate scale up of MDR-TB and XDR-TB response

Chair: Kitty Lambregts, Chair of MDR-TB Working Group

Rapporteurs: Martins Pavelsons / Fuad Mirzayev, WHO

09:00 - 09:10	Increasing laboratory capacity for XDR-TB and MDR-TB response	Karin Weyer, WHO
09:10 - 09:20	Increasing TB lab capacity in Rwanda	Michel Gasana, Rwanda
09:20 - 09:30	Q/A and D	
09:30 - 09:40	Involving all health care providers in the MDR-TB response	Mukund Uplekar, WHO
09:40 - 09:50	Involving all health care providers in Indonesia	Tjandra Y. Aditama, Indonesia
09:50 - 10:00	Q/A and D	
10:00 - 10:15	Coffee Break	

10:15 - 10:25	The Latvia WHO Collaborating Centre for Research and Training in Management of Multidrug Resistant Tuberculosis	Vaira Leimane, Latvia
10:25 - 10:35	Centres of excellence in MDR-TB management: the way to go?	Salmaan Keshavjee, Chair Green Light Committee
10:35 - 10:45	Q/A and D	
10:45 - 10:55	Progress and next steps in addressing procurement crisis in second-line anti-TB drugs	Paul Zintl, Chair sub-group on drug management MDR-TB Working Group
10:55 - 11:05	Q/A and D	
11:05 - 11:15	Developing national plans for scaling up response to MDR-TB and XDR-TB	D'Arcy. Richardson, PATH
11:15 - 11:25	The Romanian national plan to tackle MDR-TB and XDR-TB	Domnica Chiotan, Romania
11:25 - 11:35	Q/A and D	
11:35 - 11:45	Introducing TB infection control in Botswana	Vonai Teverdzi, Botswana
11:45 - 11:55	A perspective on introducing infection control in TB control programmes	Bess Miller, USA
11:55 - 12:05	Q/A and D	
12:05 - 13:05	Lunch	

session 4 — Mobilizing the resources for universal access to MDR-TB diagnosis and treatment by 2015

Chair: Ken Castro (US)

Rapporteurs: Irina Sahakyan / Martins Pavelsons, WHO

13:05 - 13:20	Targets, budgets and plans in the MDR-TB and XDR-TB response	Katherine Floyd, WHO
13:20 - 13:30	Q/A and D	
13:30 - 13:45	Are the current advocacy efforts good enough for the XDR-TB response?	Javid Syed, Treatment Action Group Case Gordon, World Care Council
13:45 - 13:55	Q/A and D	
13:55 - 14:25	How to address the funding gaps?: Donors and country perspective. (10 minutes presentation per country)	Paula Samo Gudo, Mozambique Archil Salakaia, Georgia Wang Li Xia, China Cesar Bonilla, Peru Bill Coggin, PEPFAR Stefano Lazzari, Global Fund Amy Bloom, USAID
14:25 - 14:45	Q/A and D	
14:45 - 15:00	Coffee Break	

session 5 — Recommendations

Chair: Mario Raviglione (WHO)

Rapporteur: Fuad Mirzayev

15:00 - 15:40	Report on each session	Wang. Xie Siu, China Refiloe Matji, South Africa Kitty Lambregts, WG MDR-TB Ken Castro, US
15:40 - 16:20	Q/A and D	
16:20 - 16:35	Closing remarks	Mario Raviglione, Director, STB

WORLD HEALTH ORGANIZATION

2nd Global XDR-TB Task Force meeting
9-10 April 2008
Kofi Annan Conference Room
Geneva, SWITZERLAND

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2nd Global XDR-TB Task Force meeting
9-10 April 2008
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WORLD HEALTH ORGANIZATION

2nd Global XDR-TB Task Force meeting
9-10 April 2008
Kofi Annan Conference Room
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WORLD HEALTH ORGANIZATION

2nd Global XDR-TB Task Force meeting
9-10 April 2008
Kofi Annan Conference Room
Geneva, SWITZERLAND

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WORLD HEALTH ORGANIZATION

2nd Global XDR-TB Task Force meeting
9-10 April 2008
Kofi Annan Conference Room
Geneva, SWITZERLAND

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WORLD HEALTH ORGANIZATION

2nd Global XDR-TB Task Force meeting
9-10 April 2008
Kofi Annan Conference Room
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WORLD HEALTH ORGANIZATION

2nd Global XDR-TB Task Force meeting
9-10 April 2008
Kofi Annan Conference Room
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WORLD HEALTH ORGANIZATION

2nd Global XDR-TB Task Force meeting
9-10 April 2008
Kofi Annan Conference Room
Geneva, SWITZERLAND

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WORLD HEALTH ORGANIZATION

2nd Global XDR-TB Task Force meeting
9-10 April 2008
Kofi Annan Conference Room
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WORLD HEALTH ORGANIZATION

2nd Global XDR-TB Task Force meeting
9-10 April 2008
Kofi Annan Conference Room
Geneva, SWITZERLAND

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