World Health Organization

FINAL Report: First Meeting of the re-organised Global Task force on Latent TB Infection
Date held, 25 April 2018: Time: 13.00-14:00 (Geneva local time)

The End TB strategy of WHO prioritizes the management of latent TB and TB prevention. To facilitate this, WHO established a task force on latent TB infection (LTBI) in 2015, which primarily focused on low TB burden settings. However, following the development of the 2018 harmonised and consolidated guidelines on the programmatic management of LTBI, the WHO has reorganised the LTBI task force with representation from both high and low TB burden settings. This was the first meeting of the re-organised task force.

Chairs: Kitty van Weezenbeek (KNCV) and Alberto Matteelli (University of Brescia)

Agenda of meeting:
(1) Welcome, introductions and ToR of the reorganised LTBI task force, (2) New recommendations of the consolidated and updated LTBI guidelines, (3) Barriers and innovative solutions to accelerate the implementation of the guidelines, (4) Key areas for future meetings

Members Present*:*
I. Abubakar, J. Bruchfeld, R. Cedillos, R. Cho, T. Comolet, G. de Vries, C. Denkinger, M. Frick, M. Gaga, U. Go, E. Heldal, P. LoBue, A. Matteelli, G. Migliori, L. Mvusi, I. Solovic, T. Sterling, W. Vandevelde, T. Vasankari, M. Wanlin, T. Yoshiyama, A. Date, G. Sotgiu, R. Rao, D. Cirillo, F. Dockhorn. K. van Weezenbeek.

Apologies:
M. Al Lawati, P. Andersen, R. Chaisson, S. Graham, R. Menzies, A. Story, M. van der Werf, S. Eholie, N. Van Hung, S. Futakul, A. Kamarulzaman, B. Mutayoba, B. Durovni, E. Hastuti, G. Churchyard, L. Chesire, N. Eyerusalem, S. Aboje.

WHO secretariat present:
H. Getahun, M. Rangaka, A. Kanchar, S. Singh, S. Mase.

H.Getahun welcomed the task force members, confirmed attendance, and announced the agreement of K.van Weezenbeek and A.Matteelli to co-chair the reorganised LTBI task force, following a request from the Secretariat. He explained the ToR of the re-organised task force, which will focus on both low and high TB incidence countries to accelerate the implementation of the new consolidated guidelines globally. It will provide strategic advice to WHO on norms and tools to accelerate programmatic management of LTBI, including monitoring and evaluation in all settings and across all risk groups. It will also promote research by identifying knowledge gaps and priorities.

A.Matteelli and K.van Weezenbeek chaired the meeting, and the following agenda discussed.

1. New recommendations of the consolidated and updated LTBI guidelines

H.Getahun thanked task force members for participating on the Guideline Development Group, and explained that the updated LTBI guideline consolidates WHO recommendations from several WHO guidelines and also provides new recommendations (found here). Overall, there are 24 recommendations comprising seven which were updated for clarity, existence of new evidence, seven new recommendations, and ten existing recommendations which were still valid and thus retained. He requested the task force to discuss how to harness and scale-up new recommendations, which are expected to greatly enhance implementation. The most transformative of the new recommendations include the expansion of the risk population for preventive therapy to include the HIV-negative household contacts aged 5 years or older, expansion of LTBI tests to include either IGRA or the skin test for use regardless of epidemiologic settings, and expansion of LTBI treatment options in high TB burden settings. He emphasised the implementation of the recommendations should be carefully managed so that benefit outweigh harm.

2. Discussion on barriers and innovative solutions to accelerate the implementation of the guidelines.
Members were each invited to describe a barrier to implementation and propose innovative solutions.

The following are key barriers and suggested solutions:

Availability, cost, length and safety of current regimens. Research on simple ultra-short LTBI treatment regimens, including innovative "1shot-1time-low risk" regimens; promote and improve access to, and availability and affordability of, rifapentine-based regimens such as 3HP/1HP (includes need to encourage manufacturers to develop or expedite the development of child-friendly formulations of 3HP/1HP; the need to bring more quality-assured suppliers of rifapentine to the market and provide them with guidance on what products to produce (e.g. FDCs, RPT tablets at higher doses etc.); facilitate transition to newly recommended regimens and gather programmatic evidence for safety of regimens; develop FAQs to address safety in risk-groups, including toxicity in pregnancy.

Low coverage of contact tracing. Promote contact tracing in children and adults as an extension of index case management; utilise children as an entry point to adult tracing; conduct active contact investigation instead of passive; explore differential approaches to better target individuals for contact tracing, including number needed to treat or estimates of number of contacts targeted for treatment.

High cost of diagnostics and confusing results/interpretation. Need innovation to make LTBI diagnostics simple, accessible and affordable; need tests with improved predictive ability to distinguish incipient disease from latent infection (or other points along the LTBI spectrum); need to simplify interpretation of existing LTBI tests and improve them for scale-up (IGRA and skin test); promote access to, and programmatic evaluation, of novel tests for LTBI diagnosis (e.g. C-Tb, Diaskintest).

Staff reluctance and inaction. Need to increase perception of LTBI treatment among HCW (and families of patients), need to improve messaging and ways to effectively engage and provide information; Need to involve national professional societies; Engage health workers across all levels of the health system (from programme managers to providers).

Absence of coherent national guidelines. Support countries to adapt national LTBI guidelines considering the local epidemiology and needs of the country; WHO to work with implementing partners and financing facilities, including PEPFAR and the Global Fund, to ensure TB prevention services and commodities are included in country grants and operational plans in ways that accord with global guidelines

Lack of technical tools to support implementation. Need a technical/operational handbook to guide implementation, and unpack by example, good practice in LTBI screening, treatment, follow-up of patients and evaluation of drug interactions and surveillance of LTBI treatment harm and effectiveness; also need tools to address gaps in the cascade of care (includes for supporting the management of adverse events and completion of treatment).

Research and scientific advocacy. Promote the LTBI research agenda in implementing countries and provide skills for doing research; conduct operational research and post-market evaluation of uptake of different regimens in different settings, and to assess safety and tolerability as well as effectiveness/impact; research areas also to include work among migrants and other vulnerable populations, and to encourage treatment completion in this population, to identify the best regimen for prevention of MDR TB and how to identify those eligible, and for addressing social determinants of LTBI (TB). WHO should publish content from new guideline in peer reviewed journals to reach academics.

3. Conclusion and next steps
H.Getahun concluded the meeting. Future meetings will focus on the aforementioned barriers and solutions. A doodle survey with suggested dates for the next meeting will be shared.