

# **TRANSITION PLAN FOR THE NEW GLOBAL FRAMEWORK TO SUPPORT SCALE UP TO UNIVERSAL ACCESS TO QUALITY MANAGEMENT OF MULTIDRUG-RESISTANT TUBERCULOSIS**

## **Executive summary**

This document lays out recommendations for the new global framework for supporting the scale-up of service provision for multidrug-resistant tuberculosis (MDR-TB). It includes the steps that need to be taken to implement the new framework by the deadline of 30<sup>th</sup> June 2011, set by the Stop TB Partnership (STP) Coordinating Board, and also the major new activities recommended by the transition process during the last 14 months, that need to be undertaken going forward from the deadline. An indicative budget for these activities is attached. The document has been prepared through an inclusive and iterative process by a group of partners<sup>1</sup> charged to carry out the work by the Stakeholders' Meeting on the Global Framework that met in February 2011 and arrived at a consensus on the new framework.

The main objectives of the current global framework supporting MDR-TB management, namely the Green Light Committee (GLC) Initiative, includes ensuring that the treatment of patients with MDR-TB is done in accordance with guidelines published by the World Health Organization (WHO), increasing technical assistance to facilitate rapid scale-up of MDR-TB management, increasing access to high-quality, affordable, second-line anti-TB drugs and advising WHO on policy-related matters relating to the programmatic management of MDR-TB (PMDT).

In February 2010, the key stakeholders supporting the expansion of MDR-TB services concluded that the number of MDR-TB cases receiving treatment of known quality is very small (<5%) compared to the overall burden, and that a significant improvement in this situation required an urgent revision of the global framework that addresses MDR-TB management. Moreover, support to the scale up of MDR-TB services "should explicitly shift from a controlling to a supporting mode". Three Task Forces were set up to look into: i) the provision of technical assistance; ii) availability of quality assured second-line TB drugs (SLDs); and iii) monitoring and evaluation,

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and the governance structure for MDR-TB management scale-up. The three Task Forces have worked over the past 14 months to develop the new framework and presented their recommendations to the Stakeholders' Meeting that met in February 2011.

**The main recommendations described in this plan are as follows:**

1. The successor to the GLC at the global level should be a broader-based "strategic committee at global level with a dual role of advising WHO and partners". It will be both i. a sub-group of the Stop TB Partnership's MDR-TB Working Group, and ii. an advisory committee to WHO. The Secretariat should be housed in WHO. The Green Light Committee (GLC) brand name should be preserved in the title of the new committee;
2. Future support from the global framework should focus on building national capacity to implement and manage scale-up of MDR-TB services, via greatly increased technical assistance; and that there should be a phased implementation of decentralised regional GLC entities, starting with the European, Western Pacific and American regions;
3. To increase access to high-quality, affordable, SLDs for the treatment of MDR-TB, no prior approval by the GLC will be required by countries applying to the Global Drug Facility, but their commitment to international monitoring of MDR-TB management will be required;
4. To strengthen advocacy in support of scale up of MDR-TB management by ensuring close linkages between the emerging Stop TB Partnership advocacy strategy and the messages needed for both global and national level action to accelerate universal access to MDR-TB management;
5. Regular monitoring and evaluation of country performance in accelerating access to MDR-TB treatment and care should continue to inform assessment of global progress, to propose improvements to the global, regional and national approaches, and to pursue advocacy activities tailored to country needs, and, where implemented, regional GLCs should take the lead;
6. Provision of advice to funding agencies, on their request, ensuring that the treatment of patients with MDR-TB is done in accordance with international standards should continue, with the close involvement of regional GLCs, where they are implemented. The possibility of accelerating the approval process of the Global Fund identified by this process, should be urgently pursued; and
7. Regular updating of international policy and guidelines relating to programmatic management of drug-resistant TB (PMDT) through the WHO should continue.

Indicative costings show that a 3-4 fold increase in the current level of funding is needed to meet the "bottom-line" requirements for the establishment and functioning of the new global framework i.e. an increase from the current annual investment of USD \$5-6 million currently

flowing through the GLC secretariat to approximately USD \$23 million annually flowing to the most appropriate partners. Since the writers of this report had no time to analyse budget flows for global support of MDR-TB management expansion other than those passing through WHO, further work will be required to ascertain the amount of "new" money that will be required to cover all costs recommended by the transition process.

The transition process also identified a significant gap between the need and the availability of quality assured second-line drugs. Additional work is being undertaken by the GDF and partners to explore a global humanitarian/philanthropic push to close this gap.

Following the decision of the 20<sup>th</sup> STP Coordinating Board meeting, further work will also be required for resource mobilization to fund the activities described in the plan and to revisit the current funding arrangements for the GLC and its activities with existing funding agencies and partners. Similarly, this plan outlines a communications strategy to ensure that all stakeholders are rapidly informed of the impending changes and of the steps that they will need to take.

## Section 1. Background

### **The public health issue that is being addressed**

There have been steady increases in the number of patients with MDR-TB approved each year for treatment by the GLC Committee (13,389 in 2009<sup>2</sup> and 42,033 in 2010<sup>3</sup>), and in those actually starting treatment (10,531 in 2009 and about 13,000 in 2010<sup>3</sup>). However the numbers remain small compared to the estimated annual incident 440,000 cases. This threatens the control of TB worldwide, potentially undermining the major advances made in detecting and treating TB in the past 15 years. The challenge now is how to re-structure the global organisation of the support to the expansion of MDR-TB care in such a way as to best accelerate the number of cases detected, enrolled on treatment and treated successfully, and hence achieve universal access by 2015.

### **How we got to the current situation**

At the 62nd World Health Assembly (WHA) held in May 2009, member states were urged to achieve universal access to diagnosis and treatment of MDR-TB by 2015.<sup>4</sup> The Global Plan to Stop TB 2011-2015<sup>5</sup> aims to have 1 million MDR-TB patients treated between 2011-2015, and 270,000 MDR-TB patients placed on treatment in 2015.

During 2009, key stakeholders supporting the expansion of MDR-TB services and care concluded that a revision of the global framework that addresses MDR-TB diagnosis and management was necessary. At retreats of partners convened by WHO in October 2009 and February 2010, it was agreed that a new model of coordination and support to countries was needed.<sup>6</sup> The model should **emphasize support to countries rather than control, and advocacy to ensure countries honour the commitments made at the 62nd WHA.** In addition, the new model aims to **increase access to quality assured second line drugs, and provide more, better, and more extensive technical assistance** over the short, medium and long term.

Three Task Forces were set up under the Stop TB Partnership to look into the following main areas of concern: 1) the provision of technical assistance; 2) availability of quality assured second-line anti-TB drugs; and 3) monitoring and evaluation, and the governance structure for MDR-TB management scale up. A consultancy was also contracted by the Stop TB Partnership to address MDR-TB advocacy (the report from this consultancy on advocacy was submitted to the STP in late 2010). The work of the Task Forces was presented and reviewed at the 19th Coordinating Board meeting in Johannesburg, South Africa, 14-15 October 2010. The Board requested the Secretariat to clarify a number of issues raised during their discussions. The responses were discussed at a special meeting of Board members in Berlin, Germany, on 11 November 2010. From this meeting, the Secretariat, with the MDR-TB Working Group, was requested by the Board (Annex 1) to develop a transition plan by end January 2011 and to organise a meeting of the key stakeholders to discuss the final outputs of the Task Forces and the detailed transition plan.

A meeting of key stakeholders on the "way forward to achieve universal access to diagnosis, treatment and care of MDR-TB" was held in Geneva, Switzerland, 22-23 February 2011. Agreement was reached at the meeting that: future support should focus on building national

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<sup>2</sup> GLC Annual Report 2009

<sup>3</sup> Data with GLC Secretariat, 10 February 2011

<sup>4</sup> WHA Resolution 62.15

<sup>5</sup> Stop TB Partnership. The Global Plan to Stop TB, 2011-2015: Transforming the Fight, towards elimination of Tuberculosis. WHO, 2010

<sup>6</sup> Facilitator report. MDR-TB scale-up workshop, 4-5 February 2010

capacity to implement and manage scale-up of MDR-TB services, via greatly increased technical assistance; the successor to the GLC at the global level should be a "strategic committee at global level with a dual role of advising WHO and partners", that is it will be both i. a sub-group of the MDR-TB Working Group of the Stop TB Partnership, and ii. an advisory committee to WHO; the Secretariat should be housed in WHO; and that there should be decentralised regional entities.

This document lays out what the new structures required to support the new framework are, what needs to be done to move from the current to the new framework and structures, and the roles and responsibilities of the different stakeholders during the transition period until the new framework of global support to MDR-TB scale-up is in place by 1 July 2011. The document also includes an outline of new activities that have been recommended by the three Task Forces in order to achieve rapid scale-up of MDR-TB services to meet the ambitious targets set for 2015. Indicative costings for activities required during and after the transition period are provided. However these costings will require further refinement, especially to prepare for the new environments (e.g. introduction of GenXpert / Xpert MTB RIF), and also should be seen as a "bottom-line" requirement as they do not include the funds available for supporting scale-up MDR-TB services provided through different channels and agencies involved in the current GLC Initiative.

## **Section 2. Current global mechanism that supports MDR-TB management expansion ["Point A"]**

The WHO and the Stop TB Partnership support countries to manage MDR-TB through the GLC Initiative. The GLC Initiative is comprised of the GLC Committee, the WHO/GLC Secretariat, the Global Drug Facility (GDF) and partners who provide financial and technical assistance. The GLC is a WHO advisory committee, which is also a sub-group of the Stop TB Partnership's MDR-TB Working Group.

The objectives of the GLC Initiative are to:

1. ensure that the effective treatment of patients with MDR-TB is done in accordance with guidelines published by the WHO relating to the programmatic management of MDR-TB;
2. increase access to technical assistance in order to facilitate rapid scale-up of MDR-TB management;
3. increase access to high-quality, affordable, second-line anti-TB drugs for the treatment of MDR-TB among well-performing programmes; preventing the development of resistance to second-line anti-TB drugs by ensuring rational drug use; and
4. advise WHO on policy-related matters with the objective of effectively preventing and controlling MDR-TB based on the best available scientific evidence.

Countries that do not make use of the GLC Initiative have less access to technical assistance for DR-TB and do not benefit from the monitoring missions undertaken by the GLC.

### **2.1 The role of the GLC Committee**

1. Review applications from countries that wish to benefit from access to the pooled-procurement mechanism of quality assured second-line drugs managed by GDF (the majority of which are coming through the Global Fund to fight AIDS, TB and Malaria);
2. Identify needs for technical assistance to countries throughout the application and implementation processes;
3. Monitor and evaluate GLC-approved programmes to assess their progress and continued adherence to WHO guidelines; and

4. Inform WHO of GLC findings, deliberations and recommendations, and assist WHO with developing policy to control MDR-TB.

The GLC committee is supported by the GLC Secretariat hosted and administered by WHO (hereinafter referred to as the "WHO/GLC Secretariat").

## **2.2 Responsibilities of the WHO/GLC Secretariat**

1. To coordinate and facilitate the application and review processes by mediating
2. communication between the GLC and programs (both applying or already approved by the GLC);
3. To guide programs applying to the GLC;
4. To organize and coordinate the necessary technical assistance;
5. To review applications to ensure their completeness both in terms of content and the supporting documents required for GLC review;
6. To plan, coordinate (and participate in) all official GLC meetings; record minutes of the meetings and GLC recommendations and communicate with the applicants;
7. To prepare Terms of Reference for the monitoring visits and collect progress reports from the countries in close collaboration with WHO Regional Offices;
8. To inform the Global Drug Facility about approved applications after each official GLC meeting, including the specific number of patients approved for enrolment;
9. To draft an annual report of GLC activities and finalize the report after review by the GLC Committee;
10. In the development of new policy, to coordinate with the GLC and other experts, the production and analysis of new evidence;
11. To manage the WHO/GLC Secretariat budget and financial reporting to the donors in accordance with WHO Financial Rules and Regulations.

## **2.3 The role of the GDF**

The Global Drug Facility, an arm of the Stop TB Partnership, which is also hosted and administered by WHO, carries out drug procurement for GLC-approved programmes.

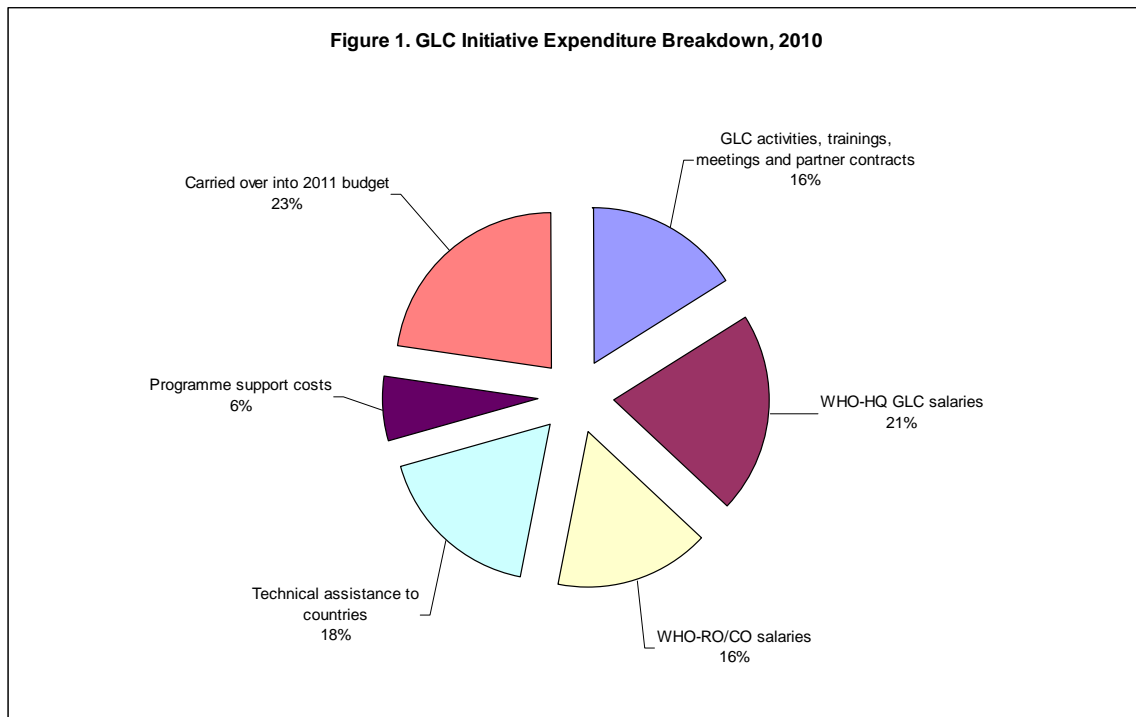
Since beginning to provide quality assured SLDs in 2007, GDF has substantially increased the number of quality-assured SLDs available for procurement through the GDF from 11 in 2008 to 25 in 2010, with the number of suppliers of SLDs tripling from 5 in 2008 to 15 in 2010. The GDF had negotiated stable and sustainable prices valid from 12 to 24 months for all products, without the conditionality of volume commitments. Through implementation of a Strategic Rotating Stockpile (SRS), funded by UNITAID, the GDF has decreased the delivery lead time for urgent orders to between 19 and 33 days. In 2010, the SRS was accessed by 52 countries/projects served by the GDF. The GDF has supplied quality-assured SLDs to a total of 74 countries, including 22 of the 27 high MDR-TB burden countries.

## **2.4 The role of WHO and partners**

The role of the WHO and technical partners is to provide the required technical assistance (TA) to those programmes and projects approved by the GLC, through contracts with WHO, which is coordinated by the GLC Secretariat. However it is important to note that support that partners provide, such as TA and other support to design and implement PMDT programmes, is also carried out outside of the GLC Initiative, utilising other funding sources (e.g. country contracts, own fundraising, GF, bilateral aid etc.). Presently there is no global overview of the extent of TA investment in PMDT by partners other than that provided via the GLC Initiative.

## 2.5 Current investment for the GLC Initiative

The present investment in the component of the GLC Initiative that is managed by WHO, is currently around USD \$5-6 million per year. This is utilised for the GLC related activities, including technical and monitoring missions to countries, the functioning of the GLC Secretariat, etc (Figure 1 and Annex 2). The total does not include the budget expenditure in 2010 related to the functioning of the section of the GDF that dealt with SLD procurement and supply issues. The total also does not include those funds currently available for supporting other aspects of scale-up of MDR-TB services, such as laboratory strengthening, infection control, etc, provided to other institutions and agencies and from different funding sources. These funds are provided to agencies that are both involved and not involved in the current GLC Initiative activities.



## Section 3. Proposed structure and functions of new framework to support scale up to universal access to quality MDR-TB management ["Point B"]

### Mission statement

To achieve a world free of drug resistant TB.

### Goal

To accelerate scale up to achieve universal access to prevention, early diagnosis and effective patient-centred treatment for drug resistant tuberculosis by 2015.

To reach this goal, the stakeholders' meeting in February 2011 concluded, the new global framework will have to provide:

1. Increased level and diverse models of technical support from all partners to assist countries to plan, implement, manage and monitor the required scale-up of MDR-TB services.

2. Increased access to high-quality, affordable SLDs for the treatment of MDR-TB.
3. Strengthened advocacy for the accelerated scale up of the response to MDR-TB.
4. Regular and supportive monitoring and evaluation of country performance in accelerating access to MDR-TB treatment and care, to inform assessment of global progress, to propose improvements to the global, regional and national approaches, and to pursue advocacy activities tailored to country needs.
5. Regular updating of international policy and guidelines relating to PMDT.
6. Provision of advice to funding agencies, on their request, ensuring that the effective treatment of patients with MDR-TB is done in accordance with international standards.

The elements of the new framework to support scale up to universal access to quality MDR-TB management are discussed below.

### **3.1 Technical assistance**

Scale-up has to take place at the country level and one of the main bottleneck identified as hindering the scale up is the lack of technical capacity and adequately developed health workforces in countries. Therefore the new framework will focus on capacity building at the country level and the provision of increased technical assistance (TA), including long term in-country TA, from all partners to develop the capacity to plan, implement, manage and monitor the required scale-up of MDR TB-services.

Technical assistance and monitoring activities will increasingly be decentralized to the regional and country levels. To further this aim, countries will be encouraged to develop their own national (or sub-national) technical assistance centres (TACs) to guide and support nationwide scale-up of PMDT, in collaboration with the regional GLC's (see section 3.3 Global and Regional GLC Committees). National technical assistance centres can have regional functions; these TACs need to be maintained and supported.

The development of national TA plans will be prioritized and TBTEAM can play an important role in the development of these plans and in the co-ordination of the TA provided to countries by the different partners. Guidance and tools are being developed for assessing and planning the human resource requirements for country-wide management of MDR-TB.

### **3.2 Availability of quality assured, affordable SLD's**

To ensure availability of quality-assured SLDs and other commodities in sufficient quantities at an affordable price and in a timely manner to all countries, a number of actions have been identified. GDF will continue to play an important role, with WHO PQ, in collaboration with ICH and other partners, needing to play an increasing role.

Under the new framework, all countries will be eligible to approach GDF directly for the procurement and supply of quality assured SLDs, with no prior application or approval process. The GDF is undergoing restructuring, including proposed regionalization of activities, to meet the new needs. All those ordering via GDF, are accountable for proper patient management and are expected to participate in a regular monitoring system through the regional GLC's, and receive TA as required.

In order to optimize the current supply system, countries need to improve their planning. To assist them in this, appropriate TA in drug management needs to be delivered and the developed forecasting tool needs to be piloted as soon as possible. Advance purchase commitment may be further explored as a novel way to increase access to quality assured SLDs. Partners will continue



efforts to provide technical assistance to suppliers in order to facilitate the prequalification process for SLDs (USP PQM).

Advocacy for greater investment and increased political commitment is needed to accelerate scale up of effective strategies and tools to achieve universal access to DR-TB management (see section 4.6 Strengthened Advocacy).

### **3.3 Global and Regional GLC Committees**

To support these activities and implementation of the new global framework, GLC Committees will be established at the global and regional levels. It is proposed that they will be known as the Global GLC at the global level and generically at the regional level as the Regional GLCs. The term "GLC" is however now to be seen as a brand name and not as an abbreviation of a specific longer form of notation. Regional GLCs will be identified by their respective geographical location e.g. EURO - GLC for the European Region. The regional secretariats may be based, but not mandatorily, in the WHO Regional Offices. The rationale of decentralization is to bring GLC activities closer to the countries and benefit from the greater involvement of key national and international partners in the scale-up of MDR-TB services and care in the respective Region. Hosting Regional GLCs in the regions would also ensure coordination of activities with other on-going TB, HIV and health system strengthening related interventions from the Regional level.

The overall objective of the Global and Regional GLCs is to provide advice to WHO, Partners and countries on strategic issues related to scaling up DR-TB care in order for countries to achieve universal access to management of drug-resistant TB (WHA 62.15).

#### **3.3.1 Global GLC Committee (hereafter referred to as "gGLC")**

##### **Role of the gGLC Committee**

The global level strategic gGLC should have the dual role of advising WHO and Partners, that is it should be both i. an advisory committee to WHO, and ii. a sub-group of the MDR-TB Working Group of the Stop TB Partnership.

##### **Terms of reference of the gGLC Committee**

1. Provide advice to WHO and Partners on strategic issues related to scaling up MDR-TB care;
2. Strengthen advocacy for increasing commitment of countries, donors and technical agencies to achieve universal access to patient-centered MDR-TB management according to WHO guidelines;
3. Monitor and evaluate global and regional scale-up of MDR-TB management to optimize regional and country strategies;
4. Promote access to high-quality, affordable second-line anti-TB drugs and other commodities;
5. Liaise with global partners in support of scale-up of PMDT for harmonization and streamlining of efforts and identification of research needs;
6. Ensure collaboration among Global and Regional GLCs to ensure consistency and communication across regions to address technical issues, programmatic challenges, and strategic planning;
7. Contribute to regular updating the evidence base, WHO policy and guidelines relating to the programmatic management of drug-resistant tuberculosis, including the rapid uptake of new tools to improve PMDT; and
8. Provide opinions to donors/funding agencies at their request on country PMDT scale-up plans and subsequent TA needs addressing identified gaps, via the global GLC secretariat.

### **Composition of the gGLC Committee**

- i. Members are to be appointed in their individual capacity; and
- ii. Members will be selected to ensure that all relevant technical areas are represented and the perspectives of a broad range of constituencies and regions are represented on the committee.

Criteria for nomination of members, technical areas and constituencies, as well as the selection process, are provided in Annex 3.

Proposed size of the gGLC is 12-15 members. A maximum of 6 members will be nominated by the Regional GLCs from their membership to represent them on the global committee and serve as liaisons between the Regional and Global GLC (i.e. 1 per region). The other members will be from the constituencies listed in Annex 2. The gGLC members are expected to meet the general requirements for providing expertise in technical areas or constituencies.

The members will serve for a term of 2 years, renewable for a second consecutive term. Renewal will be dependent on performance evaluation, based on criteria outlined in the standard operating procedures.

The chair of the gGLC will be elected based on a simple majority vote amongst the gGLC members. There will be two in-person meetings per year, at least one to be organized around an existing meeting, e.g. the UNION conference, pending of availability of funds. Ad-hoc meetings via tele/videoconference or in person, may be organized as and when required.

The secretariat of the gGLC will be housed in WHO, Geneva.

### **Terms of reference of the gGLC Secretariat**

- Issue call for nominations for members of gGLC, conduct the initial screening of applications, provide eligible applications to the gGLC Selection Committee, and communicate with selected members.
- Plan, coordinate (including preparation of background materials) and participate in the meetings of the gGLC, maintain minutes of gGLC meetings and decisions for future reference and communication with WHO, Stop TB Partnership Secretariat, the Global Drug Facility, the Global Laboratory Initiative, Regional GLCs, Partners and Member States.
- Co-ordinate and liaise with Regional GLCs.
- Manage and report to relevant donor agencies on the utilisation of funds received via the new global framework to support MDR-TB scale-up.
- Coordinate with the gGLC, the MDR-TB Working Group (WG) and other subgroups of the WG, and WHO, the production and analysis of new evidence in support of the MDR-TB policy development.
- Manage the GLC website, updating of GLC-related material, and preparation of an annual Global GLC report.
- Ensure effective links with WHO regional offices and other relevant partners.
- Manage the declaration of interest and potential conflict of interest issues, and seek legal opinion from the WHO Legal Office as and if required.
- Manage the process of replacement of members.
- Prepare and collate annual GLC report.

- Act as the collation point from Regional GLCs and secretariats to provide opinions to donors/funders on country PMDT scale-up plans and subsequent TA needs addressing identified gaps

### **3.3.2 Regional GLC Committees (hereafter referred to as "rGLC")**

Decentralization to the regions will happen in a phased manner. Regions that requested to start in the first year are AMRO/PAHO, EURO and WPRO.

#### **Terms of reference of the rGLCs**

- Review and provide inputs to the regional strategies and/or action plans for scale up of PMDT;
- Review and analyze GLC monitoring mission reports and surveillance data:
  - Identify programmatic issues that need to be addressed and recommend actions, including the provision of technical assistance and prioritization of resources.
  - Monitor scale-up progress - Programmes that have gone through this process will be considered “GLC Reviewed Programmes.”;
- Provide an opinion to donors/funding agencies on their request on country PMDT scale-up plans and the subsequent TA needs addressing identified gaps, via the gGLC Secretariat;
- Oversee the provision of supportive monitoring missions and technical assistance missions to countries;
- Liaise with the gGLC and exchange information on plans of rGLC activities, seek inputs and advice as and when required, and inform the gGLC of technical and political issues relevant to TB and MDR-TB prevention and control.
- In collaboration with WHO Regional Office and Partners, to convene advocacy efforts for PMDT scale up, access to and rational use of quality medicines, and coordinate and report on progress related to data collection in respective regions.

#### **Composition of the rGLCs**

The composition of the rGLCs should ensure that the key relevant technical areas and constituencies are represented. However, the specific composition should reflect the different needs of the respective region.

#### **Terms of reference of the rGLC Secretariats**

- Issue call for nominations for members based on transparent criteria and in collaboration with other partners, particularly the Stop TB Partnership, identify individuals in the Region with PMDT experience and authority for inclusion in the regional GLC.
- Convene and provide administrative and logistic support for meetings (face to face or via teleconference) and prepare background materials for the rGLC.
- Provide synopses of monitoring and TA mission reports to the rGLC, provide feedback to countries and communicate with gGLC.
- Maintain records and minutes of the rGLC meetings and decisions.
- Feedback to the countries' programmes and projects via the rGLC Secretariat. Major issues and important lessons will be transmitted to the gGLC and other rGLCs for discussion and comments.
- Ensure effective links with WHO country offices and NTPs and other relevant national partners.
- Plan and coordinate technical assistance to develop and/or update National PMDT plans and integrate these plans in National TB Strategic Plans and/or National Health Strategic plan (if applicable).

- Arrange PMDT-related TA, advocacy and supportive monitoring missions in close collaboration with WHO country offices and other partners, and receive the mission reports.
- Manage the declaration of interest and potential conflict of interest issues, and seek legal opinion from the WHO Legal Office as and if required.
- Manage the process of replacement of members.
- Upload all relevant documents (national plans, funding applications, technical and monitoring mission reports and reviews, etc) to a common SharePoint, and prepare a regional section of the annual GLC report.

Although it is not anticipated that AFRO, EMRO and SEARO will establish their respective rGLCs during the first year, activities should be undertaken in preparation for the time when these regions will take up all activities under the new framework. In the interim, the global level will perform certain required activities, in collaboration with the WHO Regional Offices, to ensure that countries in the three Regions receive the support required for MDR-TB management to be scaled up.

### **3.3.3 Management of Conflicts of Interest**

Conflicts of interest will be strictly managed. Thus no individual member of a GLC Committee should review reports of work or applications that s/he or her/his institution has been engaged in any way. If members declare any such involvement, they are not to be party to any discussions or decision making in relation to the specific country report or expansion plan under review.

Members are expected to declare any conflicts of interest, either relating to their involvement in the preparation of specific country or programme applications, or to direct involvement in MDR-TB related activities of a specific country or proposed programme. Each committee member will be required to complete and sign a "Declaration of Interest" form before each meeting, in addition to a one-time general confidentiality agreement.

It is the responsibility of the respective chairs to stringently apply the COI policy, e.g. to exclude the members with conflict of interest from all relevant discussions.

If TA needs are identified, there will be no further discussion within the committee, in relation to who will be contracted to carry out the TA work. The respective GLC secretariat will organize the TA, with the utmost transparency applied to the process of how the TA work is assigned.

### **3.3.4 Compensation for GLC members**

The principle here is that members of WHO advisory committees cannot be paid for their committee work - for fear that the objectivity of their advice may be biased. However, because some members are not remunerated by their institutions for the time spent on committee activities, WHO is prepared to offer GLC members an honorarium in recognition of the work they undertake for the benefit of Member States. However the amount paid as honorarium will not be calculated on the basis of time spent or volume of work performed, but will represent a recognition for the individual's commitment to the GLC. In recognition of the greater burden taken by the Chair, WHO proposes that the amount for her/him will be 1.5 times that offered to the general GLC members. Honoraria can however be declined. It is anticipated that members who accept the honorarium, will cover all relevant administrative costs with the honorarium.

### **3.3.5 Reporting structures and accountability**

In its role as a WHO advisory committee, the Global GLC will report and be accountable to the Director of the STOP TB Department, WHO. In its role as sub-group of the MDR-TB Working

Group, it will report and be accountable to the Chair of the MDR-TB Working Group. Regular updates will be provided to the Stop TB Partnership Coordinating Board and the WHO Strategic and Technical Advisory Group for Tuberculosis. An annual GLC report will be published.

## **Section 4. Actions needed to be taken during the transition period, April - June 2011**

### **4.1 Increased technical assistance**

Regarding the scale-up in the provision of technical assistance, the necessary activities are not directly linked to the scope of work required during the transition period itself. The required activities under this area are outlined in Section 5.1 on pages 16-17.

### **4.2 Increased access to high-quality, affordable, second line anti-TB medicines**

To build on the momentum seen in the last few years and to achieve the rapid scale-up aimed for, a number of actions have been identified by Task Force 2 as essential to ensuring that quality-assured SLDs and other commodities are available in sufficient quantities at an affordable price and in a timely manner to all countries. The identified actions will serve as a platform for rapid scale-up given the new structure of Regional GLCs.

1. Direct procurement of quality-assured SLDs via GDF: Under the new framework, there will be no application to nor approval requirement from the GLC for the procurement of quality assured SLDs from GDF i.e. requests for the supply of SLDs will be submitted directly to the GDF. The gGLC Secretariat and GDF will update existing documentation to reflect the new procurement process. Once the new framework is in place, the gGLC Secretariat will review the procurement forms from programmes requesting SLDs to GDF, and in consultation with the gGLC provide advice to GDF in cases where private sector orders are received or on any other specific requests, involving necessary consultations with rGLCs, including preparations and coordination of missions (review of documentation, etc. - gGLC Secretariat and GDF, May 2011 onwards / direct procurement requests to GDF, 1 July 2011 onwards).

To improve planning and forecasting, there is a need to understand the current status of SLD supply in each of the 27 MDR-TB high-burden countries, in particular those not receiving drugs via GDF and where active participation of the new GLC framework is expected:

2. Finalize data base and conduct situational analysis of SLD status in all MDR-TB high burden countries: The situational analysis would include details on the progress with implementation of diagnostic capabilities, current MDR-TB management and drug treatment policies, drug quality information, and most importantly, regulatory processes governing quality assurance of essential medicines (Partners and GDF, June 2011 onwards).
3. Implement new forecasting tool: Pilot in the countries identified for the testing of the data collection and forecasting tool (Partners and GDF, June 2011 onwards).
4. Propose a regional strategy for the scale-up of access to quality assured SLD's: Commitment to quality-assured SLDs remains non-negotiable. Countries will be prioritized for TA, based on the quality assurance status of SLD's currently procured, and on the degree of regulatory oversight already existing in the respective country. Where pre-qualified or Stringent Drug Regulatory Authority approved drugs are not used, the aim will be to facilitate assistance with quality testing in order to increase the number of approved suppliers of essential SLDs to countries that require SLDs, whilst managing the risk by ensuring that drugs received are adequately controlled for quality (rGLC, Partners and GDF, June 2011 onwards).

To place the issue of lack of access to adequate supplies of quality assured SLDs as a real humanitarian emergency, discussions need to take place at the highest political levels which brings key players around the same table to create a solution to the issue.

5. Exploration to be considered of a humanitarian/global philanthropic push to solve the issue of lack of access to quality assured SLDs (gGLC and STP, by June 2011 - see section 4.6 Strengthened advocacy on page 15).

#### **4.3 Planning, monitoring and evaluation**

Country performance will be monitored and evaluated annually through an expanded collection of national data by WHO and the results will be published in the WHO Annual Global TB Control Report.

1. Further work to define the indicators and hence data to be analysed after the on-line collection from countries and to be published in the WHO Annual Global TB Control Report (WHO and gGLC Secretariat, April to May 2011).

Assessment of country progress and performance will be undertaken by the Global and Regional GLCs utilizing information from monitoring and technical missions, and data collected from the countries and from in-country partners.

2. Development of systems and/or adapting current systems (making use of web tools, etc) to enable unified data collection on PMDT scale-up via the Regional and Global GLC Secretariats (Global and Regional GLC Secretariats, WHO TME and MDR teams, by June 2011).
3. Continued organization of monitoring missions to assess programmatic aspect of country progress and performance (Global and Regional GLC Secretariats, April to June 2011)
4. Review, finalize and harmonize existing assessment, monitoring and planning tools for PMDT (gGLC Secretariat and Partners, by June 2011).
5. Orientation of Regional GLC members to build their capacity to ensure effective functioning of the Regional GLCs (gGLC Secretariat and Partners, June 2011 onwards).

#### **4.4 Relationships with funding agencies and countries**

Under the current GLC Initiative, there are existing agreements with funding agencies, and also agreements between the Initiative and countries. These will need to be reviewed in light of the new proposed framework and any implications acted upon.

1. Define the implications of the new framework for the existing Letter of Agreement with GLC approved projects/countries, and decide upon revisions if required (WHO STB and STP [GDF], by May 2011).
2. Define the implications of the new framework for the existing Memorandum of Understanding with the GF and for existing agreements with other funding agencies (e.g. UNITAID) and decide upon revisions if required (WHO STB and STP, and GF and other funding agencies, by May 2011).

To improve the efficiency of the assistance provided to countries and the GF in relation to both application to the GF for funding support and implementation of activities of grantees, it is proposed that the provision of TA will occur earlier than currently occurs under the existing mechanism. TA will be provided to assist countries develop or update their national MDR-TB scale-up plans, and also to support countries and the GF during the grant negotiation period. This

proposal will need to be presented to, discussed with and approved by the GF as soon as possible after the STP Co-ordinating Board has endorsed the transition plan.

3. Approach the GF to harmonize grant negotiation, with earlier provision of TA to applicants and grantees: The GF needs to be approached and discussions entered into for the establishment of a mechanism for collaboration with the GLCs, and on the requirements for the MDR-TB component of the GF R11 proposals (gGLC Secretariat and GF, by May 2011).

#### **4.5 Governance of new framework**

During the transition period, the Global and Regional GLCs and their respective secretariats need to be established and the procedures put in place to make these bodies operational. This will involve the issue of a call for nominations for members of the respective committees, and selection of members (details for the selection process are provided in Annex 3). During the first year, it is proposed that regional committees will be established in AMRO, EURO and WPRO. In the first year, the global level will perform certain required activities, in collaboration with the WHO Regional Offices and other regional partners, to ensure that countries in the three other Regions (AFRO, EMRO and SEARO) receive the support required for MDR-TB management to be scaled up. However during the first year, activities should be undertaken in preparation for the time when these regions will take up all activities under the new framework.

Oversight of the functioning of the Global GLC in its role as a sub-group of the MDR-TB Working Group will be with the Chair of the MDR-TB Working Group, Stop TB Partnership, and in its role as a WHO advisory body with the Director, Stop TB Department, WHO. Regular updates will be provided to the Stop TB Partnership Coordinating Board and the WHO Strategic and Technical Advisory Group for Tuberculosis.

1. Establishment of the Global and three Regional GLCs (STP and WHO, by June 2011).

#### **4.6 Strengthened advocacy**

Advocacy for greater investment and increased political commitment is needed to accelerate scale up of effective strategies and tools to achieve universal access to MDR-TB management. STP must ensure that advocacy related to PMDT is integrated into a broader TB advocacy strategy, in order to take the MDR-TB agenda forward by all partners. To support PMDT advocacy activities, a "DR-TB advocacy manual" will be needed to support activities of country-level as the new GLC framework is scaled up.

Stop TB Partnership is to take the lead on defining advocacy priorities relating to DR-TB by:

1. Reviewing existing GLC-related advocacy documents, website and guidance documents to feed into the STP advocacy strategy (gGLC Secretariat and STP, by June 2011).
2. Work with partners to identify advocacy priorities to support the expansion of MDR-TB management, including a humanitarian / global philanthropic push to solve the issue of access to quality assured SLDs, as well as a call for more regulatory action at the country level for the rational use of SLDs. This would be part of a comprehensive advocacy strategy for TB (gGLC and STP, beginning in June 2011).
3. STP to designate a staff member to focus on resource mobilization issues, with particular focus on the Global Fund and UNITAID. However this is dependent on the availability of funds to support a new staff position (STP, by June 2011).

#### **4.7 Updating of evidence base, and WHO policy and guidelines relating to PMDT**

The members of the Global and Regional GLCs will contribute to the updating of the evidence

base, and WHO policy and guidelines relating to PMDT. An updated edition of the current WHO PMDT Guidelines will soon be published and therefore no specific actions need to be taken during the transition period in relation to this.

#### **4.8 Communication of new framework and transition**

For the smooth transitioning to the new global support framework, it will be important that member states, current GLC approved programmes and projects, partners and key stakeholders are fully informed of the proposed changes to the current GLC Initiative and progress in the transition. Crucial will be the provision of timely and clear information in relation to the processes of the new framework, especially where there are differences from the current ones. It is proposed that regular (monthly) mailshots are provided to all involved with updates on progress in the transition to the new framework. More targeted communication will be made with the relevant agency or stakeholders involved in specific activities during the transition period.

The following summarizes some of the key timelines for communicating information to the key stakeholders during the transition phase (April- June 2011):

April 2011: The STP Secretariat will communicate the decision points from the Coordinating Board meeting in Washington DC to all stakeholders. These decision points will be incorporated into the transition plan, budget and the terms of reference for the Global and Regional GLCs.

The implications of the new framework on existing MoUs (WHO STB and STP) and LoA (GDF) will also be reviewed in April with partners. By the end of the month, a call will go out inviting nominations from those individuals who wish to serve on the Global and Regional GLCs.

May: Information will be widely distributed on the formation of the Global and Regional GLCs, the respective Secretariats and the processes. An advocacy document on DR-TB and a concept paper on the humanitarian appeal for greater access to second-line drugs will be distributed early in the month.

June: A document/presentation will be prepared for the WHO Strategic and Technical Advisory Group meeting.

The Global and Regional GLCs, and their respective Secretariats will be operational before the end of the month, and information will be provided to countries and stakeholders that the system will be live on July 1.

More details are provided in Annex 4.

### **Section 5. Activities that are to be continued and/or started from July 2011 onwards after the transition period is ended**

#### **5.1. Increased technical assistance**

These activities are linked to the recommendations made by Task Force 1 in order to have an expanded approach to technical assistance (TA) for MDR-TB scale-up.

1. Establishment of in-country TB advisor(s) positions in the low and middle income high TB or high MDR-TB burden priority countries, based on a needs assessment and in coordination with the WHO Regional Office, national programmes and partners (50 advisors in 23 countries).



2. Training courses be provided, including a mentoring of trainees post-training, with a quality assurance system to ensure that global, regional and in-country experts providing national level TA are fully trained on all aspects of PMDT and health system developments that affect TB control.
3. Paper prepared laying out the HR requirements for the national management of MDR-TB.
4. Foster the career development of young professionals in public health medicine, and in particular relating to TB and MDR-TB.
5. Proposal developed for support of National Technical Assistance Centres (TAC), submitted to a funding agency for support, and support provided to countries to establish National TACs.
6. Organization and coordination of technical support:
  - Mapping exercise be conducted of current TA provided by all partners for MDR-TB related activities, and an analyses undertaken of the effectiveness of the TA provided, the results of which are to be shared with all partners.
  - GLC monitoring and TA missions and data collection for countries (100) to be coordinated, planned and supported by rGLC and gGLC Secretariats, in collaboration with the WHO TME unit in Geneva.

## **5.2 Increased access to high-quality, affordable, second line anti-TB medicines**

The actions 1 to 4 described under Section 4.2 on page 13 will continue after the transition period is ended. In addition:

1. GDF re-organization: The proposed reorganization of the GDF will be completed. Included in the proposed re-organization is a decentralization of activities with the establishment of eight Regional Support Officers positions, based at the global (1) and regional levels (7).
2. Drug management related assistance: In the coming 12 months period, ten country missions will be conducted for drug management assistance in collaboration with partners involved in drug management.

## **5.3. Planning, monitoring and evaluation**

1. Continued organization of monitoring missions to assess programmatic aspect of country progress and performance (Global and Regional GLC Secretariats).
2. Orientation workshops with Regional GLC members to build their capacity to ensure effective functioning of the Regional GLCs - orientation workshops with members of the 3 rGLC in Year 1 and for the members of the remaining 3 rGLCs in Year 2 (gGLC Secretariat and Partners).

## **5.4. Strengthened advocacy**

1. Implementation of a comprehensive advocacy strategy to support the expansion of DR-TB management, including a humanitarian / global philanthropic push to solve the issue of access to quality assured SLDs, as well as a call for more regulatory action at the country level for the rational use of SLDs (STP).
2. Development of a "DR-TB Advocacy Manual" and work plan outlining the roll out of the manual. Conduct trainings on "Advocacy for DR-TB" in all regions with priority given to GLC countries (STP and WHO).
3. WHO TB Monitoring and Evaluation, Operations and Co-ordination teams and partners prepare and submit a paper to the Lancet, or other high impact journal, on the future probability, extent, timeline, and costs of the subsequent control required, of MDR-TB strains replacing current TB strains (WHO and Partners).
4. Coordinating Board meeting of the Stop TB Partnership systematically reviews progress in advocacy and resource mobilization for scale-up of MDR-TB services (gGLC and STP Secretariats).

## **5.5 Governance of new framework**

Establishment and maintenance of Global and Regional GLC committees, and their respective secretariats:

- Year 1 - establishment and maintenance of Global GLC Committee and 3 Regional GLC Committees, and their respective Secretariats.
- Year 2 - establishment and maintenance of the remaining 3 Regional GLC Committees and their respective Secretariats, and maintenance of the established gGLC and 3 rGLCs, and their respective Secretariats.

For the gGLC, activities and costs for maintenance are related to the organizing and holding of gGLC meetings, honorarium for the gGLC members, and for the running of the gGLC Secretariat, and for the performance of the functions covered under the TOR for the gGLC.

For the rGLCs, activities and costs are related initially to the establishment of the rGLCs and then to the maintenance of the rGLCs (organizing and holding of rGLC meetings, honorarium for the rGLC members, and for the running of the rGLC Secretariats), and for the performance of the functions covered under the TOR for the rGLCs.

## **5.6 Updating of evidence base, and WHO policy and guidelines relating to PMDT**

As and when required, GLC members may be invited to attend meetings called by WHO for the review and/or development of new PMDT related Policy and Guideline documents.

## **5.7 Communication of new framework and its activities**

Communications between the gGLC and the rGLCs, and to Partners, donor/funding agencies, countries, etc. will be done in order to perform the functions covered under the TORs for the gGLC and rGLCs.

## **Section 6. Resources needed for the implementation of the new framework**

Sections 4. and 5. provide an outline of the actions that are needed to be undertaken during the transition phase and also the new activities that have been endorsed by the February 2011 Stakeholders meeting in order to achieve rapid scale-up of MDR-TB services to meet the ambitious targets set for 2015.

An overview of the indicative budget estimates that are needed to implement these activities is provided below (further details are provided in Annex 5). However these costings will require further refinement, especially to prepare for the new environments (e.g. introduction of GenXpert / Xpert MTB RIF). In addition, it must be noted that for comprehensive scale-up to universal access of DR-TB management, additional activities are required that are not addressed in the estimates presented below. The estimates do not include those funds currently available for supporting other aspects of scale-up of MDR-TB services, such as laboratory strengthening, infection control, etc, provided through different channels and agencies both involved and not involved in the current GLC Initiative, or future requirements. Thus the below estimates should be seen as a "bottom-line" requirement for the implementation of the new framework and the recommendations made by the Task Forces.

Indicative costings show that a 3-4 fold increase in the current level of funding is needed to meet the "bottom-line" requirements for the establishment and functioning of the new global framework i.e. an increase from the current annual investment of USD \$5-6 million currently flowing through the GLC secretariat to approximately USD \$23 million annually flowing to the

most appropriate partners.<sup>7</sup> Since the writers of this report had no time to analyse budget flows for global support of MDR-TB management expansion other than those passing through WHO, further work will be required to ascertain the amount of "new" money that will be required to cover all costs recommended by the transition process. In addition, during the transition period, discussions need to be held with those funding agencies who express interest in being potential funding sources to support the implementation of the activities of the new framework.

Without the availability of new and additional funding, support to the global scale-up of MDR-TB services will continue. However it will be at a much reduced level than hoped for and will reduce the likelihood of achieving universal access to diagnosis and treatment of MDR-TB by 2015.

Table 1 below presents the estimated costings for Year 1 and Table 2 for Year 2. More detailed breakdown of the budget requirements are given in Annex 5.

**Table 1 Estimated costings for Year 1, April 2011 - March 2012 (in USD)**

Increased technical assistance <sup>a</sup>	Increased access to high quality, affordable, second line anti-TB medicines	Strengthened advocacy	Governance of new framework				TOTAL <sup>b</sup>
			Global GLC		Regional GLC (3 regions - AMRO, EURO, WPRO)		
			Activities	Salaries	Activities	Salaries	
17,570,000	3,073,000	282,000	127,000	1,049,000	346,000	671,500	<b>\$23,118,500</b>

**Table 2 Estimated costings for Year 2, April 2012 - March 2013 (in USD)**

Increased technical assistance <sup>a</sup>	Increased access to high quality, affordable, second line anti-TB medicines	Strengthened advocacy	Governance of new framework				TOTAL <sup>b</sup>
			Global GLC		Regional GLC (all 6 regions)		
			Activities	Salaries	Activities	Salaries	
16,700,000	2,923,450	232,300	156,000	1,016,600	592,000	1,284,430	<b>\$22,904,780</b>

<sup>a</sup> Includes establishment of in-country TB advisor(s) positions, training courses, support for National Technical Assistance Centres, and GLC monitoring and technical assistance missions.

<sup>b</sup> Total figure does not include programme support costs.

To conclude, the final goal of this framework is enable countries to accelerate the scale- up of MDR-TB management in order to be on track towards the target of universal access to diagnosis and treatment by 2015. Realigning the process of coordination between partners to support countries is one focus of the new framework described here, and the respective transition from the previous model of work. The funding requested for the framework will enable WHO and partners to coordinate more effectively the support needed by countries.

<sup>7</sup> Funding would be made available through the partner, technical agency, implementer, country, or institution who is best positioned to implement the proposed activities.

**Annex 1 Decision Points of the Special Session of the Stop TB Partnership Coordinating Board on MDR-TB, 11 November 2010, Berlin, Germany**

*Moving towards a new framework for supporting countries to scale-up MDR-TB management (2.10-4.0)*

Recognizing and commending the excellent work of the MDR-TB Working Group since our meeting in Johannesburg in October 2010, the Board:

- Strongly endorses the proposed shift from project management to integration of MDR-TB management into national TB programmes with a view to achieving universal access.
- Endorses the process of transition based on the broad components of the framework as presented by the MDR-WG. *(The draft paper needs to be sharpened and become an official document so that it can be referenced.)*
- Requests the Stop TB Partnership secretariat to develop with the MDR-TB working group a detailed transition plan by the end of January 2011 to include, but not limited to, resources needed for implementation of the new system including management of technical assistance, drug procurement (working with GDF), the roles and responsibilities of the TBTEAM, WHO, Stop TB partnership secretariat, donors, countries, etc. The transition plan should also articulate the oversight of the proposed functions by WHO and the Stop TB partnership CB.
- The transition plan should be developed in consultation with partners including affected communities, civil society, donors and implementing countries.
- The transition plan should be presented for discussion at a broad consultation to be held before the end of January 2011. It needs to be submitted to the CB for approval at next CB meeting in April 2011.

**Annex 2 GLC Expected Income and Expenditure, 2011 (USD \$) <sup>8</sup>**

Donor	Expected Income (including carry forward balance)	Expected Expenditure Breakdown					Total expected expenditure	Expected balance
		GLC activities, trainings, meetings and partner contracts	WHO-HQ GLC salaries	GLC regional services		Programme support costs		
				WHO-RO/CO Salaries	Technical assistance to countries			
<b>USAID PEPFAR</b>	2,498,536	0	775,894	0	1,435,200	287,442	2,498,536	0
<b>Global Fund</b>	5,295,133	1,224,000	584,481	1,276,697	1,176,085	233,870	4,495,133	800,000
<b>UNITAID /TBP</b>	174,000	0	174,000	0	0	0	174,000	0
<b>ELI LILLY</b>	210,000	60,000	0	0	135,000	15,000	210,000	0
<b>WHO- Regular Budget</b>	33,000	0	33,000	0	0	0	33,000	0
<b>TOTAL</b>	8,210,669	1,284,000	1,567,375	1,276,697	2,746,285	536,312	7,410,669	800,000

<sup>8</sup> As presented to the Stakeholders meeting, Geneva, Switzerland, 22-23 February 2011. Covers the component of the GLC Initiative that is managed by WHO.

## **Annex 3 Selection process for the GLCs**

### **Selection process**

#### *1. Technical areas (focused on drug-resistant TB)*

Programmatic management of MDR-TB care  
Clinical care, including paediatric and HIV-infected patients  
Patient support and nursing care and case holding strategies  
Drug management  
Laboratory  
Infection control  
Epidemiology and surveillance, and information systems  
Advocacy

#### *2. Constituencies*

Civil Society  
Technical partners  
Implementing partners  
International non-governmental organizations  
Private sector health care providers  
Academia and research institutions  
Donor/funding agencies  
Countries - NTP representatives from a high burden country  
Regional GLCs (i.e. maximum of 1 per Regional GLC, 6 in total)

Members may cover more than one technical area or constituency in order to be cost efficient, and improve coordination of cross cutting issues. Should it be required advice will be sought from outside experts.

### **Selection process for members of the Global GLC**

Call for nominations issued by WHO and the Stop TB Partnership, with eligibility criteria which addresses the individual's expertise and experience in the areas of work and constituencies to be covered within the GLC. Initial screening of received applications is to be done by the GLC Secretariat to confirm that applicants meet the eligibility criteria. Screened applications are then provided to the Selection Committee for its recommendations on the selection of the members of the GLC.

### **Composition of Selection Committee (9 members)**

Representative from civil society  
GLC representative  
Chair of MDR-TB WG or nominated representative from MDR-TB Core Group, plus one more  
Representative of the WHO ROs  
Representative of the GLI  
Representative of GDF  
Representative of the gGLC Secretariat  
Country representative

The inclusion of any individual as a member of the Selection Committee for the Global GLC, will preclude that individual from being considered as a member of the Global GLC.

The secretariat will do initial screening. The selection committee will meet in person to recommend members for selection. The representatives may need to refer back to their

institutions where it makes sense. The selection committee needs to reach consensus on its recommendations. The selection outcome is to be announced to all stakeholders.

It is suggested that the establishment of the regional committees follows the same principles as for the global selection process. The Regional Committees should be selected by a selection committee that will include at a minimum a representative of the Regional Stop TB Partnership and of the WHO Regional Office. If no Regional STP exists, a representative from a key partner from the region or the MDR-TB core group should be co-opted, in consultation with the Global Stop TB Partnership.

**Annex 4      Communication plan on new global framework to support MDR-TB scale-up and the transition to new framework**

**MARCH**

<b>Information to be communicated</b>	<b>Responsible</b>	<b>Recipients</b>	<b>4th week</b>
Final report from Stakeholders meeting	GLC Secretariat	All invited meeting participants & STP Secretariat	
Final Summary Sheet for STP CB meeting	GLC Secretariat	STP Secretariat	
Final Transition Plan for STP CB meeting	GLC Secretariat	STP Secretariat	
Final products of three Task Forces for STP CB meeting	Convenors of the three Task Forces	STP Secretariat	

**APRIL**

<b>Information to be communicated</b>	<b>Responsible</b>	<b>Recipients</b>	<b>1st week</b>	<b>2nd week</b>	<b>3<sup>rd</sup> week</b>	<b>4<sup>th</sup> week</b>
Decision points from STP CB meeting	STP Secretariat	All stakeholders WHO ROs for transmission to WCOs and member countries, GLC approved programmes and projects, and partners and key stakeholders				
Outcome of Stakeholders meeting and decision points from the STP CB meeting	Global GLC Secretariat					
Review document on implications of new framework on existing MoUs and revisions if required	WHO STB & STP	WHO STB & Legal, and STP				
Review document on implications of new framework on current LoA and revisions if required	WHO STB & STP (GDF)	WHO STB & Legal, & STP (GDF)				



Establishment of global and regional GLCs and secretariats	WHO HQ & Phase 1 ROs, and STP	Call for nominations for experts who wish to serve on the respective GLCs issued; process begins to identify staff for Regional GLC Secretariats	[Redacted]			
Review document on implications of new framework on existing MoUs and required revisions (if needed)	WHO STB & STP	Relevant funding agencies				
<b>MAY</b>						
<b>Information to be communicated</b>	<b>Responsible</b>	<b>Recipients</b>	<b>1st week</b>	<b>2nd week</b>	<b>3<sup>rd</sup> week</b>	<b>4<sup>th</sup> week</b>
Draft concept document on accelerating timing of proposal review and earlier provision of TA to applicants and grantees	Global GLC Secretariat	GF WHO ROs for transmission to WCOs and member countries, GLC approved programmes and projects, and partners and key stakeholders	[Redacted]			
Update on progress of transition period	Global GLC Secretariat	Nominations from experts received, screened by the respective GLC Secretariats, and selection process to serve on the respective GLCs initiated;	[Redacted]			
Establishment of global and regional GLCs and secretariats	WHO HQ & Phase 1 ROs, and STP	process initiated to identify staff for secretariats	[Redacted]			

**JUNE**

Information to be communicated	Responsible	Recipients	1st week	2nd week	3 <sup>rd</sup> week	4 <sup>th</sup> week
Information on global and regional GLCs, and secretariats, and processes (including set of revised GLC related documents and guidelines)	WHO & STP	WHO ROs for transmission to WCOs and member countries, GLC approved programmes and projects, and partners and key stakeholders	■			
Documentation for presentation to WHO STAG	WHO STB & Global GLC Secretariat	WHO STB Directors Office	■			
Revised web-site and Sharepoint for global and regional GLCs	Global GLC Secretariat	Global and Regional GLCs Experts selected to serve on the respective GLCs and informed of decision; process to identify staff for secretariat(s) completed	■	■		
Establishment of global and regional GLCs and secretariats	WHO HQ & Phase 1 ROs, and STP	WHO ROs for transmission to WCOs and member countries, GLC approved programmes and projects, and partners and key stakeholders	■			■
Information that new framework is going live on 1 July 2011	WHO & STP					■

## Annex 5. Indicative budget estimates, Years 1 and 2

Deliverables	Requirements	Estimated Cost (USD)	
		Year 1	Year 2
<b>Increased technical assistance</b>			
1. Establishment of in-country TB advisor(s) positions in the priority low and middle income high TB or high MDR-TB burden countries. Countries based on a needs assessment and in coordination with the WHO Regional Office, national programmes and partners	1-2 in-country international advisors (P4 level - for PMDT Capacity Building and/or, Laboratory Capacity Building and/or Clinical and Drug Management Capacity Building) in low and middle income high TB or high MDR-TB burden priority countries.	\$10,000,000	\$10,200,000
2. Training courses be established, with a quality assurance system to ensure that global, regional and in-country experts providing national level TA are fully trained on all aspects of PMDT and health system developments that affect TB control	Estimates of number of consultants and in-country advisors required.	\$1,000,000	\$1,000,000
	Costings of training and mentoring.		
	Needs outsourcing to a consortium to conduct regular training activities.		
3. Paper prepared laying out the HR requirements for the national management of MDR-TB	Consultant for 2- 3 months on APW with WHO (ongoing work).	\$20,000	
4. Foster the career development of young professionals in public health medicine, and in particular relating to TB and MDR-TB	Fellowships courses offered.	\$500,000	\$500,000
	Accredited courses on PMDT, through professional organizations / registration etc.		
5. Proposal developed for support of National/Regional Technical Assistance Centres	Needs to include estimates of HR including international staff initially, infrastructure and equipment, and running costs for trainings, etc. WHO Regional Offices will need to work with priority member countries to undertake regional planning.	\$3,000,000	\$2,000,000
6. Organization and coordination of technical support			
a. Mapping exercise to be conducted of current TA provided by all partners for MDR-TB related activities, and an analyses undertaken of the effectiveness of the TA provided, the results of which are to be shared with all partners	Consultant for 3 months on APW with WHO who will communicate with all technical partners, TBTEAM and WHO Regional Offices to map the TA support and budget spent for line items related to MDR-TB support	\$50,000	
b. GLC monitoring and TA missions and data collection for countries (100) to be coordinated, planned and supported by regional teams in collaboration with HQ. Does not include other parallel activities provided by WHO and other partner agencies in laboratory, infections control and other relevant areas	Monitoring and TA missions provided for countries.	\$3,000,000	\$3,000,000

Deliverables	Requirements	Estimated Cost (USD)	
		Year 1	Year 2
<b>Increased access to high-quality, affordable, second line anti-TB medicines</b>			
1. Situation analysis (complementary to GDF database on product quality information): Providing information, per country, on quality of each product used in each country, indicating if WHO pre-qualified, sNRA approved, or ERP-approved. Identification of bottlenecks/TA needs.	External consultancy on technical aspects; Exchange of required information between GDF and rGLC.	\$20,000	
2. Support data collection for assessment of short- and medium-term forecasting tool in pilot countries, also recognizing impact of laboratory strengthening and expansion of diagnostic capability.	Finalization of electronic reporting tools to be used at country level; engagement with NTPs, including training; full use of Partners.	\$800,000	\$700,000
3. GDF reorganization			
a. Human resource - regional support officers	Staff - 8 P3/P4 positions - 1 global and 7 regional	\$1,803,000	\$2,073,450
b. Drug management related assistance	10 ad hoc country missions at 15,000	\$150,000	\$150,000
c. Develop priority listing of countries for TA on facilitating registration of drugs, promoting the recognition of the quality assurance standard of WHO, and strengthening national drug management systems.	Consultant for 3 months on APW for all 6 regions.	\$300,000	
d. Develop country-specific strategies for scale-up. These would serve to guide procurement actions, TA goals, and programmatic strengthening.			
<b>Planning, monitoring and evaluation</b>			
1. Continued organization of monitoring missions to assess programmatic aspect of country progress and performance (Global and Regional GLC Secretariats).	Refer to Increased technical assistance 6.b		
2. Training of Regional GLC members to build their capacity to ensure effective functioning of the Regional GLCs - training for 3 Regional GLC members in Year 1 and for the members of the remaining 3 Regional GLCs in Year 2 (Global GLC Secretariat and Partners).	Refer to Governance of new framework 2.b		

Deliverables	Requirements	Estimated Cost (USD)	
		Year 1	Year 2
<b>Strengthened advocacy</b>			
1. Stop TB Partnership secretariat designates, as part of its advocacy team, a staff to focus solely on resource mobilization, and to take as a major priority, development and maintenance of a constant stream of messages focused on TB, and specifically MDR-TB, directed at the Board, its two major committees, and any WG established by these three.	Staff - 1 P4 staff	\$202,000	\$232,300
2. Train civil society and national programmes on "Advocacy for DR-TB" (STP and WHO).	Consultant for 3 months on APW to draft the plan	\$50,000	
	Costs for printing manual and the training of national activists		
3. WHO TB Monitoring and Evaluation, Operations and Co-ordination teams and partners prepare and submit a paper to the Lancet, or other high impact journal, on the future probability, extent, timeline, and costs of the subsequent control required, of MDR-TB strains replacing current TB strains.	Consultant on APW to draft the first manuscript	\$30,000	
4. Coordinating Board meeting of the Stop TB Partnership systematically reviews progress in advocacy and resource mobilization for scale-up of MDR-TB services.	Include in the Board's agenda and briefing documents prepared		

Deliverables	Requirements	Estimated Cost (USD)	
		Year 1	Year 2
<b>Governance of new framework</b>			
1. Global GLC			
a. Global GLC meetings	2 meetings per year - 12 persons in Year 1 and 15 persons in Year 2	\$100,000	\$120,000
b. Honorarium of members as appropriate (excluding Regional GLC representatives)	3,000 per member (9 members in Year 1 and 12 members in Year 2)	\$27,000	\$36,000
c. Global GLC secretariat	Staff - 1 P5, 1 P4, 3 P3 and 1 G4 in Year 1; 1 P5, 1 P4, 2 P3 and 1 G4 in Year 2	\$1,049,000	\$1,016,600
2. Regional GLC (phased approach: 3 regions in Year 1 - AMRO, EURO and WPRO; remaining regions in Year 2)			
a. Regional GLC meetings	2 meetings for each region - 8 persons per region; total - 6 meetings in Year 1, 12 meetings in Year 2; ad hoc virtual meetings as needed	\$210,000	\$420,000
b. Honorarium of members as per regional policy (6 members per region)	2,000 per member (6 members each per region)	\$36,000	\$72,000
c. Regional GLC secretariat - for each of the 3 regions	Staff - 1 P4 and .5 G4 per region	\$671,500	\$1,284,430
d. Startup / training costs for regional GLCs	Training to be organized for regions	\$100,000	\$100,000
<b>GRAND TOTAL</b>		<b>\$23,118,500</b>	<b>\$22,904,780</b>