Report of the "Stakeholder meeting on the way forward to achieve universal access to diagnosis, treatment and care of MDR-TB", 22-23 February 2011, World Health Organization, Geneva, Switzerland

Background

At the 62nd World Health Assembly held in May 2009, member states were urged to commit to achieving universal access to diagnosis and treatment of MDR-TB by 2015, by implementing several measures to tackle the health care systems issues that are hampering progress in the response to the epidemic. The Global Plan to Stop TB 2011-2015 aims to have 1 million MDR-TB patients treated between 2011-2015, and 270,000 MDR-TB patients placed on treatment in 2015.

Faced with concerns that the number of MDR-TB cases treated is very small compared to the estimated annual 440,000 incident cases, the 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 convened by the World Health Organization (WHO) in October 2009 and February 2010, it was agreed that a new model of coordination and support to countries was needed. The February 2010 retreat advised the establishment of three Task Forces to look into: i) the provision of technical assistance; ii) availability of quality assured second-line anti-TB drugs; and iii) monitoring and evaluation, and the governance structure for MDR-TB management scale up.

The work undertaken by the three Task Forces, and a consultancy that addressed MDR-TB advocacy, was presented and reviewed at the 19th Stop TB Partnership (STP) Coordinating Board (CB) meeting held in Johannesburg, South Africa from 14-15 October 2010. Whilst recognizing and commending the work done by the Task Forces, the Board however requested the Secretariat to clarify a number of issues raised during their discussions. The responses to these issues were discussed at a special meeting of the Board members in Berlin, Germany, on 11 November 2010. From this meeting, the Secretariat, with the MDR-TB Working Group (WG), was requested by the Board 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 prior to the next Board meeting on 31 March - 1 April 2011.

A meeting of the key stakeholders was organised by WHO in Geneva from 22 to 23 February 2011 (Annex 1).[1] Sixty two participants attended the meeting, representing a wide range of technical and donor agencies, member states, WHO (Country, Regional and Global levels), the three Task Forces, the MDR-TB WG, Global Drug Facility, and STP Secretariat (Annex 2).

Meeting Objective

To achieve consensus on the way forward to accelerate scale-up of MDR-TB management, in particular to agree on the global framework for supporting the scale-up of MDR-TB management.

Specific objectives

1. To agree on the global framework for supporting the scale-up of MDR-TB management.
2. To present the final outcome of the three Task Forces.
3. To agree on the approach to, and implementation of, the transition plan.
4. To define roles and responsibilities for the finalisation of the transition plan and the new framework and their initial implementation.

Expected outcomes

1. Agreed global framework for supporting scale-up of MDR-TB management and transition plan, with defined roles and responsibilities, for presentation to the Stop TB Partnership Coordinating Board meeting, 31 March - 1 April 2011.
2. Finalization of the process of the three Task Forces for presentation to the Stop TB Partnership Coordinating Board meeting, 31 March - 1 April 2011.

[1] All presentations are available at xxxxxxx

Opening and welcome of the participants

Jeremiah Chakaya and Blessina Kumar, Co-Chairs of the meeting, Mario Raviglione, Director, Stop TB Department WHO, and Lucica Ditiu, Executive Secretary, Stop TB Partnership, welcomed the participants and reminded everyone of the purpose of the meeting, namely to reach agreement on the new global framework for supporting the scale-up of MDR-TB services by countries and thereby serving the people with MDR-TB.

Day 1, Session 1

The Green Light Committee (GLC) Initative and WHO's role

The history of the WHO/GLC response to MDR-TB was presented by Charles Daley, Chair of the GLC. Participants were reminded that the GLC committee is only one component of the overall GLC Initiative and that this needed to be kept in mind during the ensuing discussions. It was highlighted that although the GLC had approved an ever increasing number of patient treatments, the number comprised only a small proportion of the overall total of MDR-TB patients. The gap between the number of patients approved by the GLC and the number of patients actually enroled on treatment was also highlighted.

The role of WHO in the GLC Initiative was presented by Paul Nunn, Coordinator, Stop TB Department WHO. The need for agreement on the new global framework was stressed and that WHO and partners need each other. In order to comply with established regulations governing WHO committees, the need to change the ways of working of any committee that replaces the GLC, if advisory to WHO, was highlighted.

Background and recommendations of the Stop TB Partnership Coordinating Board meetings in Johannesburg (October 2010) and Berlin (November 2010)

The background and recommendations of the STP Board meetings in Johannesburg (October 2010) and Berlin (November 2010) were presented by Aamir Khan, Chair of the MDR-TB WG. The relevant decision points and recommendations from the two meetings of the Coordinating Board were presented. Most pertinent to the meeting were the decision points from the November 2010 meeting in Berlin, namely: Secretariat & MDR-TB Working Group to develop a detailed transition plan; conclude the final outputs of the 3 Task Forces; agree on new global framework to support expansion of MDR-TB care; and address the major features of the transition plan.

Session 2

Outcome of Task Force 1

The outcomes and recommendations of Task Force 1 (TF1) were presented by Agnes Gebhard, Co-convenor of TF1. Tasks assigned to TF 1 were to: describe an expanded approach to the provision of technical assistance; define the spectrum of technical assistance (TA); consider options for the decentralization of TA; and develop a template to help identify country needs for programmatic management of drug-resistant TB (PMDT) scale-up.

Recommendations from TF1

1. WHO and partners to develop clear guidance for countries on how to address human resource needs by Q2 2011, including advocacy messages.
2. Technical Assistance Centres
    a. Countries should establish (or maintain) National Technical Assistance Centres (TAC).
    b. Chairs of the MDR-TB WG Group, GLC Committee, and GLC secretariat to develop a proposal by Q2 2011 for support of National TACs for consideration by funding agencies.
3. The partnership to conduct an assessment of TA needs, current practices of TA provision, coordination, effectiveness of TA, gaps and funding levels.
4. Based on the situational and needs assessment, the international partners should:
    a. meet to address gaps in TA capacity, establish systems to monitor effectiveness of TA and funding;

    b. develop and fund well targeted training for local and international PMDT consultants, NTP Managers/PMDT Focal Points; and
    c. Prepare a coordinated training and mentoring plan to be ready by the end of Q2 2011.
5. Based on the situational assessment, a global body to be set up to coordinate the development of the increased TA needed, closely linked to structures that will continue to address monitoring for MDR-TB management and the regional level.
6. International development agencies should urgently provide funding for the establishment of long-term in-country TA positions.
7. The STP should develop a comprehensive advocacy strategy to support the expansion of MDR-TB management, including an "MDR-TB advocacy manual" and a work plan to train national activists from 2011-2012.
8. The STP Secretariat should designate a staff to focus on Global Fund issues.
9. Epidemiological modeling of MDR-TB management scale-up to inform future policy advocacy messages.
10. The STP Coordinating Board meeting systematically to review progress on MDR-TB.

Points agreed by the meeting included:

- The focus of the new framework should lie on national capacity building.
- The new framework needs to provide an increased level of technical support from all partners to assist countries to plan, implement, manage and monitor the required scale-up of MDR-TB services.
- Technical assistance and monitoring activities should be decentralized to the regional/ country level wherever possible.
- National technical assistance plans should be developed. TBTEAM mechanism can be used to develop national TA plans to avoid duplication of efforts of different partners.
- Guidance and tools should be developed (and are being developed) for assessing the human resource (HR) requirements for country-wide management of MDR-TB and associated costs. These tools should assist countries develop HRD components of MDR-TB scale-up plans.
- Countries to establish national technical assistance centres, which can have a regional function; these are to be maintained and supported. The exact positioning within a respective country will depend on the specific country setting - however they need to be integrated into existing NTP structures.
- Although *Advocacy* was not included in the primary scope of the work of Task Force 1, the meeting felt that the recommendations made by the Task Force were appropriate and that advocacy and communication activities needed to be urgently improved.

Participants were reminded that a concise summary with clear recommendations and deliverables, including responsible persons, timelines and funds needed, will need to be developed after the meeting and submitted to the Coordinating Board.

Session 3

Outcome of Task Force 2

The outcomes and recommendations of Task Force 2 (TF2) was presented by Bernard Fourie, Co-convenor of TF2. Task Force 2 was mandated to make recommendations on the actions required to make quality assured second line anti-TB medicines (SLDs) and other commodities available in sufficient quantities at an acceptable price in a timely manner to all countries.

Four products based on expected outcomes or deliverables were presented and discussed:

1. Database with product quality information, providing information on quality of each product/manufacturer/indicating if WHO pre-qualified, etc. The data base is ready and will be available via the GDF website. The new software will allow linking of the database with WHO and GDF websites.

2. Short and medium term forecasting; relevant data collection activities. The concept for a pilot project in a number of selected countries developed by a sub-group of the TF2, was shared with the participants. The preparatory activities for the pilot project have started.
3. GDF re-organizes itself to respond to the outcomes of the two expert committees (Forecasting and Advance Purchase Commitment) and the recommendations made by the Boston Consulting Group. Implementation planning of the GDF re-organization is underway. Further details were provided during the afternoon session of 22 February 2011 when an update on the GDF was presented.
4. Advance Purchase Commitment (APC). A study had been commissioned by TF2 with Dalberg, with the objective of better understanding what actions are needed to go from the current supply constrained situation to the desired market dynamic and to inform the design of an APC for selected SLDs. The study explored the following potential interventions**:**
    - **Volume commitments** are not necessarily needed from the perspective of lead time reduction / stock-out prevention, which would be the most common argument for commitments in other health commodity markets. Any volume commitment should be tailored / customized, and conservative in timeline and overall commitment (due to uncertainty in demand forecasts). The implementation of volume commitments will require additional investment in GDF strategic procurement and demand forecasting capabilities.
    - **Registration support** can be used via Partners to incentivize manufacturers to expand markets into countries with low demand for drugs. The economics of smaller countries (small volumes versus registration investments) are unattractive for manufacturers. The payment per manufacturers per country would depend on the actual registration costs and efforts, and would be positioned as a goodwill investment.
    - The dependency on a limited set of active pharmaceutical ingredient (API) suppliers remains an ongoing concern in nearly all API markets. This situation will be difficult and costly to mitigate by the GDF, and the most cost-effectiveness intervention is likely investment in **contingency planning.**
    - An **expansion of the strategic stockpile** would increase the emergency buffer and reduce delivery times. The costs and benefits of this expansion have not been analysed.

    The study concluded that an advance purchase commitment mechanism alone is not necessarily needed, but can be evaluated as part of various market developments.

During the discussions, it was pointed out that the outcome of the APC study was endorsed by all but one of the members of TF2. The concern was raised that the availability of rapid diagnostic tests and GDF's willingness to response to tenders had not been considered in the report. This may change the picture and make the APC relevant. The study report was also criticized in that it seemed to be oriented towards risk avoidance rather than supporting ambitious scale up. The global capacity is nowhere close to meeting the epidemiological need, and currently the gap between availability of quality assured SLDs and epidemiological need appears impossible to close. However, after some discussion, there was acknowledgment of the dilemma that to date, the estimated numbers of patients based on epidemiological estimates have not materialized in terms of orders. Companies thus are faced with a small market for drugs with a short shelf life, and hence entering into the pre-qualification process is not attractive to them.

The meeting participants felt that a discussion needs to take place at the highest political levels, at such fora as the Pacific Health Summit, placing the issue of access to adequate supplies of quality assured SLDs as a real humanitarian emergency which brings potential manufacturers, donor agencies, politicians from the G8 countries around the same table to create a solution to the issue.

Points agreed by the meeting included:

- The new framework needs to provide for increased access to quality assured, affordable, second-line anti-TB drugs for the treatment of MDR-TB.

- 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 developed forecasting tool should be piloted as soon as possible.
- In order to optimize the current system, countries need to improve their planning. To assist them in this, appropriate TA in drug management needs to be delivered.
- The option of pursuing advance purchase commitments should not be entirely discarded.
- All those ordering via GDF are accountable for proper patient management and therefore are expected to participate in a regular monitoring system, and receive TA as required.
- STP to explore the call for a humanitarian/global philanthropic push to solve the issue of availability of quality assured SLDs, as well as a call for more regulatory action at the country level for the rational use of SLDs.

Session 4

Outcome of Task Force 3

The outcome and recommendations of Task Force 3 (TF3) were presented by Salmaan Keshavjee, Co-convenor of TF3. TF3 was tasked with describing the future mechanism of monitoring and evaluation, and the governance structure for MDR-TB management scale up.

Recommendations from TF3

1. A new sub-group of the MDR-TB Working Group, the sGLC subgroup,[2] should be created to help countries and donors understand the needs of each programme in order to effect achievement of universal access.
    - sGLC will be a sub-group of the MDR-TB Working Group of the STP. It will be convened and funded by the STP on behalf of the member organizations, with the WHO as a standing member.
    - With the decentralization of DR-TB coordination to the WHO Regional Offices, the subgroup will have regional chapters that will seek to assist the WHO and technical/ implementation agencies at the regional level.
    - sGLC will serve as an independent expert panel evaluating programme strategies for DR-TB scale-up and identifying gaps that will require further technical and financial inputs.
    - sGLC will consist of technical experts drawn from the membership of the STP.
    - The International sGLC subgroup will focus on broader strategic questions regarding scale-up of DR-TB treatment in high-burden countries, as well as the pace of DR-TB treatment globally.
    - Regional sGLC chapters will evaluate programmes in the key areas outlined in the WHO PMDT guidelines. Each programmatic area will receive an evaluation of "satisfactory" or "requires improvement" with detailed remarks and advice for each of the areas. This information will be shared with the International sGLC subgroup for broader analysis.
    - The sGLC subgroup will regularly review the global response to MDR-TB treatment scale-up, review progress of countries, and will inform advocacy efforts of the Stop TB Partners, including the WHO.
2. Better coordination and use of data (at multiple levels) to ensure that Stop TB Partners are aware of the technical assistance needs of countries and identify key areas for advocacy.
3. Countries will no longer be required to submit an application to access quality assured drugs. All countries will be automatically eligible to purchase quality-assured medications through GDF, or through appropriate mechanisms that follow Global Fund procurement policies.

During the discussions, it was clarified that what had been presented by the TF3 Co-convenor had not been endorsed by the members of the TF3 and hence all recommendations etc were presented for the purpose of discussion by the meeting participants. There was general agreement that the function of the new framework had to be clear before moving onto any discussion on the structure. The ensuing discussion focused mainly on the function and the

[2] sGLC is used as a place holder name throughout the report until the final name of the new body is agreed.

structure of the sGLC, and where the sGLC and it's respective Secretariat should sit. It was highlighted that when it comes to especially the monitoring function, having a body in the STP would be quite different from having it in WHO, and that how this would be perceived by the Member States needs careful consultation with the Member States and consideration of their views. WHO is the Secretariat of the World Health Assembly and when WHO establishes advisory bodies, this follows standard WHO rules and regulations.

A number of concerns were raised and discussed relating to the proposed decentralization process and how the Regional sGLCs will link to the countries, provision of TA and the proposed TACs.

Points agreed by the meeting included:

- Countries will no longer be required to submit an application to access quality assured SLDs via GDF.
- Decentralisation of co-ordination of TA and monitoring missions to the Regional level.

Although in this session consensus was seemingly reached on the general overview of the functions of new body, the Chair identified a number of unresolved issues from TF3 which needed to be discussed further on the second day (23 February 2011). These included the relationship of the new body to WHO and the STP, the siting of the Secretariat of the new body, the name (particularly whether the name GLC should be retained or not), and the linkages and relationships between the Global and the proposed Regional bodies. The meeting participants agreed that the TF convenors, representatives of WHO and the STP, and the members of the core group of the MDR-TB WG, should meet on the morning of 23 February 2011 to discuss these issues further. Feedback from this meeting was to be provided to the Chair prior to the first session of the second day.

Session 5

Update from the Global Drug Facility

An update on the Global Drug Facility (GDF) was presented on behalf of the GDF Chief Operations Officer by Kaspars Lunte, GDF. The presentation included the GDF's progress through 2010, the GDF's quality assurance (QA) policy, plans for 2011, steps involved in the procurement of SLDs, sourcing of new suppliers, and proposed changes in the GDF structure.

GDF's progress: The number of quality-assured SLDs available for procurement through the GDF has increased 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 the implementation of a Strategic Rotating Stockpile (SRS), funded by UNITAID, the GDF has decreased the median delivery lead time for urgent orders to 19 days. In 2010, the SRS was accessed by 52 countries/projects served by the GDF. The GDF successfully met an increased demand for quality-assured SLDs from supplying 19 countries in 2007 to 54 countries in 2010.

GDF's QA policy: Information on the GDF's quality assurance policy can be found at http://www.stoptb.org/gdf/drugsupply/quality_sourcing_process.asp.

GDF plans for 2011: In 2011, all countries will be eligible to procure SLDs from the GDF directly. Countries would have to demonstrate satisfactory performance of MDR-TB management programme, as determined by monitoring missions coordinated by WHO. Any request for SLDs should be endorsed by the respective NTP. For countries wishing to purchase part of an SLD regimen from GDF while sourcing the remainder themselves, the NTP must comply with same quality standards as GDF. Hence products procured by the country themselves must be pre-qualified by WHO, or products which are authorized by an Stringent Regulatory Authority, or assessed by an Expert Review Panel and granted positive opinion for procurement purposes for limited period of time. Countries would have to confirm in writing their compliance on this.

For the sourcing of new drug suppliers, the GDF plans to convene several manufacturer meetings in 2011, engage in cooperation with Government Institutions and Partners to identify new suppliers and promote preparing their dossiers for submission to the WHO PQP. Preliminary group manufacturer meetings are planned in India (March), Geneva (existing manufacturers – May) and China (May), with follow up meetings later on during 2011.

Proposed changes in the GDF's structure: During 2010, the Boston Consulting Group (BCG) was retained by the STP to assess the future direction of the GDF and advise the STP Coordinating Board. Among other recommendations, BCG has proposed a 3 team structure for GDF in the future. These 3 teams include: country support (serving as focal points with clients); market development (to understand cost drivers and influence market dynamics); and business services (for performance monitoring, donor reporting and communications).

Update from the Global Laboratory Initiative
An update from the Global Laboratory Initiative (GLI) was presented by Tom Shinnick, Vice Chair of the GLI. The GLI is a Working group of the STP, with the Secretariat housed in the Stop TB Department of WHO. A core group of 12-15 individuals evaluates, approves, and governs projects, and provides advice to the GLI Secretariat. A GLI Partners Committee advises on and approves GLI's strategic agenda, and monitors project progress. The GLI's mission is to provide laboratory strengthening and a platform for coordination. The GLI works through the Supranational Reference Laboratory Network (SRLN). All 27 high MDR-TB burden countries are linked with the SRLN, and the SRLN provides TA to these countries.

The EXPanding Access to New Diagnostics for TB Project (EXPAND-TB) was presented. The EXPAND-TB Project is funded by UNITAID and key project partners include GLI, the Foundation for Innovative New Diagnostics (FIND) and GDF. The goal of the project is to expand access to diagnosis so that 129,000 MDR-TB patients will be diagnosed by the end of the project (2013). The project involves a 3-phased approach: i. laboratory preparedness; ii. introduction of new diagnostics; and iii. impact assessment. The primary tools used in the Project include liquid cultures and line probe assays, which require a lot of effort in developing infrastructure. The use of Xpert MTB/RIF Assay in future will provide the opportunity to bypass the process of building significant infrastructure. It will increase the detection of MDR-TB cases - however careful planning needs to be done to ensure that the resultant ability to increase the diagnosis of MDR-TB cases is matched with the capacity for treatment and care.

WHO Monitoring and Evaluation Activities
Philippe Glaziou, TB Monitoring and Evaluation Unit (TME), WHO Stop TB Department, presented the monitoring and evaluation activities of the WHO Stop TB Department outside of the GLC Initiative. The goals of the activities conducted by WHO TME include: strengthening of TB surveillance at the country level; monitoring progress in TB control; and estimating the burden of TB at the global level. Activities conducted to reach the goal include the use of the online TB data collection system to collect annual data from member countries, development of electronic systems for data management, workshops with countries; and policy development.

Products of the activities conducted include: The Annual WHO Global TB Control Report, electronic TB datasets publically available; Global Health Observatory reports; 2010 WHO M/XDR-TB Global Report on Surveillance and Response; financial forecasting used in the Global Plan to Stop TB 2011-2015; Stop TB Policy Paper on TB Impact Measurement; and Handbook on TB Prevalence Surveys.

Day 2, Session 6

Summary of discussion from Day 1 and on the unresolved issues from TF1 to 3
Jeremiah Chakaya, Co-Chair, presented the summary of Day 1 discussions focusing on the recommendations and unresolved issues from the three Task Forces.

Task Force 1 dealt with increasing the technical support from all partners to assist countries to plan, implement, manage and monitor the required scale-up of MDR-TB services. Broad agreement was made that: the focus lies on national capacity building; on quantifying TA needs and that the TBTEAM mechanism should be utilized to assist countries develop their national TA plans; and on providing guidance for assessing the HR requirements for country-wide management of MDR-TB and associated costs. The process should involve decentralization to the regions in line with TF1 and TF3 recommendations. National technical assistance centres should be established by countries and maintained/supported. Some of these could play a regional role. The recommendations made by TF1 relating to advocacy were agreed upon. More details are provided on pages 2 and 3.

Task Force 2 dealt with increasing access to quality assured, affordable, SLDs for the treatment of MDR-TB. A data base with product quality information will be available via the GDF website. Forecasting tools to provide estimates for short term SLD needs have been developed and are being piloted. The concept of advance purchase commitment, although not recommended currently, should not be entirely discarded. Exploration of a humanitarian approach/global philanthropic push to increase access to quality assured SLDs is needed. All countries will become eligible to approach GDF directly for the procurement and supply of quality assured SLDs. All those ordering via GDF are accountable for proper patient management and are expected to participate in regular monitoring, and receive TA as required. More details are provided on pages 4 and 5. Two issues identified that needed further discussion were related to potential scenarios where i. private sector bodies apply to the GDF for SLDs and ii. receipt by GDF of partial procurements requests.

Task Force 3 dealt with describing the mechanism of monitoring and evaluation, and the governance structure for MDR-TB management scale up. From the meeting earlier on 23 February 2011, it was agreed that there should be a "strategic committee at the global level with a 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. The Secretariat to the global committee should be based in WHO. Membership of the committee should be based on individuals and not organizations, with regional representation on the global committee. There should be decentralized entities at the regional level. Decentralization should be implemented in a phased manner taking into account the regional specifics. The WHO Regional Offices and whoever is key in the regions and countries will guide countries to scale up PMDT. Countries will no longer be required to submit a GLC application in order to access quality assured SLDs via GDF. Two issues identified that needed further discussion were the name of the successor of the GLC, and the details of the linkages between the regional and global bodies.

Lastly an overview of the new global framework was presented, comprising of:

1. Increased level 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, low-cost, SLDs for the treatment of MDR-TB.
3. Regular monitoring and evaluation of country performance in accelerating access to MDR-TB treatment and care, to inform assessment of global progress and to propose improvements to the global, regional and national approaches, and to pursue advocacy activities tailored to country needs.
4. Strengthened advocacy.
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.

Representatives from the Bill and Melinda Gates Foundation, the Global Fund, UNITAID and USAID provided their feedback on the recommendations and outcome of discussions from the three Task Forces. In summary, there was a positive note of commitment and support from these donor agencies to the agreed recommendations as long as the framework is responsive to countries' needs, including guaranteed access to quality assured SLDs and timely provision of the required quality TA. It is important that MDR-TB control activities demonstrates and shows value

for money, and that there is an appropriate mechanism in place to ensure investment and show results for the investments.

Country participants provided their feedback on the recommendations and outcome of the discussions from the three Task Forces. The participants discussed the MDR-TB situation at the country level and the challenges being faced to scale up MDR-TB management and care. In summary, the participants expressed their agreement with the outcome of discussions from the three Task Forces. The countries recognized the value of TA to address the challenges of MDR-TB and the importance of having increased access to QA drugs. Regionalization was seen as beneficial since it will bring the support closer to the countries and that the people involved will potentially be more familiar with the local setting. The countries also recognized the need to promote and highlight advocacy. They looked forward to the development and introduction of new tools for the diagnosis and treatment of MDR-TB patients. WHO and partners were acknowledged for support to countries to scale up MDR-TB services, and WHO needs to continue to provide direction for MDR scale-up.

Approaches to transition planning
An approach to address the actions and tasks that need to be carried out during the transition period towards the implementation of the new framework was presented by Fraser Wares, Stop TB Department, WHO. The presentation followed the six point overview of the new framework presented in session 6.

1. Increased level of technical support from all partners is needed to assist countries to plan, implement, manage and monitor the required scale-up of MDR-TB services.
- Establishment of the strategic sGLC at global level, regional sGLCs, and their respective secretariats:
    - Fine-tuning of the Terms of Reference for the global and regional sGLCs and Secretariats
    - Development of standard operating procedures
    - Eligibility criteria and procedures for selection of members defined
    - Establish sGLCs and secretariats, and make operational, including HR
- Define process of decentralization to regions

2. Increased access to high-quality, low-cost SLDs for treatment of MDR-TB.
- Humanitarian approach / global philanthropic push for greater access to drugs to be explored

3. Regular monitoring and evaluation of country performance in accelerating access to MDR-TB treatment and care, to inform assessment of global progress and to propose improvements to the global, regional and national approaches, and to pursue advocacy activities tailored to country needs.
- Monitor and evaluate country performance annually through an expanded collection of national data and publish in the WHO Annual Global TB Control Report
- Define roles of sGLC and secretariats in process of review of monitoring missions
- Define process by which sGLC reviews the progress of countries in building capacity for universal access to diagnosis of MDR-TB and effective use of that capacity to achieve that goal

4. Strengthened advocacy and communication.
- Discussions between STP and the group defining the roles and responsibilities of the sGLC and secretariat on how to take advocacy issues forward
- Revision of existing GLC related advocacy documents, website and guidance documents

5. Regular updating of international policy and guidelines relating to PMDT.
- No change to the current system needed

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.

- Define process of review of proposals as requested by funding agencies (ensuring no Conflict of Interest)
- Approaching the GF to accelerate timing of proposal review to coincide with grant negotiation, and earlier provision of TA to applicants and grantees
- Define implications of new framework on existing MoUs and revisions if required

The meeting agreed that the approach presented was a good start to planning for the transition. However further work is needed to refine the recommendations agreed upon at the meeting and to develop the transition plan. It was proposed that a small group with wide representation from amongst the stakeholders present at the meeting should be identified to further discuss and finalise the transition plan, containing the details as requested by the STP CB at the Berlin meeting in November 2011. The meeting agreed with this proposal and that the "transition plan" group should consist of the Chair of the current GLC, the Chair of the MDR-TB WG, Conveners and Co-conveners of the three Task Forces, and representatives from the regions, countries, civil society and the GLI. The first meeting of this group was held immediately following the stakeholders meeting on 23 February 2011. The final draft of the transition plan is to be submitted to the STP Secretariat by 15 March 2011 for discussion and decisions at the STP CB meeting, 31 March - 1 April 2011. The target date for the new framework to be in place is 1 July 2011.

The representatives from the regions and WHO Regional TB Advisors (RAs) were requested to take the lead in the development of the terms of reference of the regional GLCs, with support from GLC members and secretariat. The meeting was informed that the regional representatives had already started work on a draft document, which would be shared with the "transition plan" group and WHO RAs for further discussion and input. The meeting was informed that AMRO / PAHO, EURO and WPRO had been identified by the regional representatives as regions to which decentralisation should be considered for in the first Year.

Each Task Force was requested to summarize it's recommendations in light of the points agreed at the meeting. The Task Forces have defined the content of the new framework, whereas the transition plan will now outline the process of how to move from the current to the new framework.

Funding

The expected 2011 income and expenditure for GLC-related work was presented by Paul Nunn, WHO. If income is received as expected and in a timely manner, a proportion could be used for the increased TA proposed under the new framework and for the decentralisation of the current GLC activities. For the proposed decentralisation to the regional level to be implemented, adequate resources both in terms of funding and human resources will need to be available. Such financial implications of the new framework will be included in the transition plan to be submitted to the STP CB meeting. It was pointed out that the presented overview only referred to funding at the WHO headquarters level and that it did not capture funding from the Global Fund for technical assistance, or funds from USAID to WHO Regional and Country offices, or funds that are received by other partners that may be (re-)programmed for MDR-TB technical assistance. All funds and human resources potentially available for MDR-TB TA need to be transparently presented before a decision can be made on any movement of funds or people.

Name of new body

There was a strong plea to keep the name "GLC" in some form, due to the good work done under the name and it's disappearance would be hard to explain, especially at the country level. However some participants felt that although the GLC had done good work, since there is a paradigm change to universal access and a supportive environment, it would be wise to have a new name to go along with the new functions. To resolve this issue, the meeting held a vote on whether the GLC acronym should be retained - 36 participants voted in favour and 5 against. The meeting thus agreed to keep the GLC acronym in the name, but to ensure that meaning had changed. The regional bodies will add the regional acronyms to the name e.g AFRO….

Closing and next steps

Jeremiah Chakaya and Blessina Kumar as Co-Chairs, Lucica Ditiu and Mario Raviglione thanked all the participants and congratulated the group for the progress made during the two days. With this, the focus can now be on the important work of supporting scale up of MDR TB management in countries. Mario Raviglione closed the meeting by citing Winston Churchill: *This is not the end. It is not even the beginning of the end. But it is, perhaps, the end of the beginning.*

Annex 1. Meeting agenda

Tuesday, 22 February 2011

Co-chairs: **Dr JM Chakaya & Ms Blessina Kumar**
Rapporteurs: **Angelito Bravo (WHO STB), Susanne Carai (WHO STB), Ekaterina Kurbatova (CDC) and Sarah Royce (PATH)**

08.00 - 09.00	Registration	
09.00 - 09.15	Opening and welcome of the participants	Mario Raviglione & Lucica Ditiu
	Declaration of Conflict of Interest Objectives of the meeting	Jeremiah Chakaya
09.15 - 09.35	The GLC mechanism and WHO's role	Charles Daley & Paul Nunn
09.35 - 09.45	Background and recommendations of the Stop TB Partnership Coordinating Board meetings in Johannesburg (Oct 2010) and Berlin (Nov 2010)	Aamir Khan
09.45 - 10.00	Points of clarification	All
10.00 - 10.30	*Coffee Break*	
10.30 - 10.45	Outcome of Task Force 1	Agnes Gebhard
10.45 - 11.45	Discussions and unresolved issues from TF1	All
11.45 - 12.00	Outcome of Task Force 2	Bernard Fourie
12.00 - 13.00	Discussion and unresolved issues from TF2	All
13.00 - 14.00	*Lunch Break* *13.00 - 13.40 Presentation of preliminary results of PETTS study, Peter Cegielski*	
14.00 - 14.15	Outcome of Task Force 3	Salmaan Keshavjee
14.15 - 15.30	Discussion and unresolved issues from TF3	All
15.30 - 16.00	*Coffee Break*	
16.00 - 16.20	Update from GDF Points of clarification	Kaspars Lunte All
16.20 - 16.40	Update from GLI Points of clarification	Karin Weyer All
16.40 - 17.00	Monitoring and Evaluation activities of WHO Points of clarification	Philippe Glaziou All

17.00 - 18.30 Meeting of rapporteurs and Co-chairs to prepare summary of discussions from Day 1 and the unresolved issues from TF 1 to 3

Wednesday, 23 February 2011

Co-chairs: **Dr JM Chakaya & Ms Blessina Kumar**
Rapporteurs: **Angelito Bravo (WHO STB), Susanne Carai (WHO STB), Ekaterina Kurbatova (CDC) and Sarah Royce (PATH)**

09.00 - 09.45 09.45 - 10.30	Summary of discussions from Day 1 and on the unresolved issues from TF 1 to 3 Discussions	Jeremiah Chakaya All
10.30 - 11.00	*Coffee Break*	
11.00 - 11.30 11.30 - 13.00	The Ways Ahead for the Global Governance of the Expansion of MDR-TB Management Discussions	Aamir Khan & Paul Nunn
13.00 - 14.00	*Lunch*	
14.00 - 15.30	Summary of discussions and drafting of recommendations	Chairs
15.30 - 16.00	*Coffee Break*	
16.00 - 16.45	Approaches to finalising the transition plan, roles and responsibilities and initial implementation of the transition plan and the new framework Discussions	TBD All
16.45 - 17.00	Closing and next steps	Mario Raviglione & Lucica Ditiu

Annex 2. List of participants

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Stakeholder meeting on the way forward to achieve universal access to diagnosis, treatment and care of MDR-TB

22 to 23 February 2011

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WHO Headquarters

45. **Mario Raviglione, STB**
46. **Paul Nunn, TBC/STB**
47. **Leopold Blanc, TBS/STB**
48. **Diana Weil, STB**
49. **Karin Weyer, TBL/STB**
50. **Anant, Vijay, STB**
51. **Angelito Bravo, TBC/STB**
52. **Susanne Carai, TBC/STB**
53. **Philippe Glaziou, TME/STB**
54. **Wieslaw Jakubowiak, TBC/STB**
55. **Ernesto Jaramillo, TBC/STB**
56. **Issa Matta, Senior Legal Adviser**
57. **Pierre Yves Norval, TBC/STB**
58. **Fraser Wares, TBC/STB**

Stop TB Partnership

59. **Lucica Ditiu, TBP**
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61. **Kaspars Lunte, GDF**
62. **Paloma Marroquin Lerga, GDF**