

1st Meeting of the Global GLC Committee  
6 and 7 October 2011, World Health Organization, Geneva, Switzerland

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## Meeting report

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## Welcome of Participants and Declaration of Conflict of Interest

Dr Mario Raviglione, Director, STB, WHO, welcomed the members of the gGLC committee and congratulated them for their selection to serve on the Global GLC committee.

He reminded all participants that the biggest scandal in TB control nowadays is the fact that MDR-TB patients are not being detected and not put on treatment: This committee will focus on advice for policy guidance to be used to push countries to honor the commitment made in the WHA resolution and reach universal access to services for MDR-TB management.

Dr Raviglione urged the gGLC members to find the right spirit to carry out their functions in order to accelerate the response to the MDR-TB challenge.

Dr Lucica Ditiu, Executive Secretary, STOP TB Partnership, thanked the gGLC members for taking the time to serve on the committee and participate in this meeting.

She emphasized the urgency for action: the TB community needs to push harder as it has been two years and longer that the same numbers are being repeated.

The availability of second line anti-tuberculosis drugs is of crucial importance to address the problem, however, the programmatic aspects on how to get the drugs to the patients is of at least the same importance.

Dr Aamir Khan, Chair of MDR-TB working group, concurred with the urgency for action against the spread of MDR-TB and urged the gGLC member that the dual role of the gGLC of advising WHO and partners both as a sub-group of the Stop TB Partnership's MDR-TB Working Group and an advisory committee to WHO should be seen and used as strength and not be reason for confusion.

Dr Chuck Daley, Chair of the gGLC, thanked the speakers and lead through the introduction of the participants. The confidentiality undertaking was signed by all gGLC members and interests were declared and discussed. No conflict of interest was identified.

## Session 1 - New Global Framework and TOR for gGLC and its Secretariat

Objective: To orientate gGLC members on the new global framework to support expansion of MDR-TB care and services, and the role and function of the gGLC in the framework

Dr Paul Nunn, Coordinator, MDR team, presented the *Overview of the new global framework to support expansion of MDR-TB care and services* summarizing the outcome of the transition process from the old to the current GLC and the structure and function of the current GLC mechanism. The presentation can be found at:

<http://workspace.who.int/sites/PMDT/Global/1stGLC/default.aspx?RootFolder=%2fsites%2fPMDT%2fGlobal%2f1stGLC%2fDocument%2oLibrary%2fi%2fgGLC%2omt g&FolderCTID=&View=%7b00154F3F%2d2DA7%2d4E5D%2dA77B%2dC3CFD65D4oFA%7d>

During 2010/2011 there was a Stakeholder consensus to revise the Global Framework to support expansion of MDR-TB services which "should explicitly shift from a controlling to a supporting mode" and focus on

- Increasing provision of TA
- Increasing coordination of TA aimed at nation- wide MDR-TB services, via TBTEAM, WHO Country Offices, Regional Offices and HQ
- Expanding monitoring and evaluation of country performance annually, with results published in the WHO Annual Global TB Control Report
- Increasing advocacy in coordination with Stop TB Partnership
- "Streamlining" the process for countries applying for GF support

To support these activities it had been decided to decentralize GLC activities to the regions and set up regional committees (rGLCs) advising WHO Regional Offices and partners with Secretariats housed in "partner agencies". This decentralization to regions is being implemented in a phased manner: American, European and Western Pacific have set up rGLC in Year 1 (2011).

Currently a debate is taking place on the delay imposed on 3 "second-tier" regions (African, Eastern Mediterranean and South East Asian Region) as well as on a potential competitive bidding for the establishment of the rGLC Secretariats. Furthermore, the Global Fund may have the intention to revise the existing Memorandum of Understanding in relation to the GLC initiative and to instead support the "regional entities".

**Discussion:**

The question was raised who would call for the competitive bidding for the r-GLC secretariats?

Dr Lucica Ditiu pointed out that the Global Fund should not be in the position to dictate what the MDR TB community should or should not do – but that countries should rather make plans and decide on ways how to scale up and the Global Fund and other funders should then come into play to fund the activities or part of them. She also reminded the participants that the stakeholders had agreed during the transition process that the Regional Secretariat of the rGLCs could be housed by a STOP TB partner and thus the selection of the partner to establish the Secretariat should be carried out in a transparent and fair manner through competitive bidding in order to identify who is best suited to assume the functions of the rGLC Secretariat.

The Chair reminded the participants that this topic would be addressed specifically during a later session and closed the discussion.

\*

Dr Fraser Wares, gGLC secretariat, presented the TOR of gGLC and Meeting Objectives.

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;

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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
7. communication across regions to address technical issues, programmatic challenges, and strategic planning;
8. 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
9. 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.

The objectives of the 1<sup>st</sup> gGLC meeting:

- To orientate gGLC members on the new global framework to support expansion of MDR-TB care and services, and the role and function of the gGLC in the framework
- To review progress of MDR-TB management scale up in high-burden countries and selected other countries, to identify common major bottlenecks and strategies to address them
- To provide specific advice on:
  - collection of evidence for shorter treatment regimens for MDR-TB, and on the introduction of new anti-TB drugs
  - how to address the bottlenecks between diagnostic services, treatment management services, and second line drug supplies to ensure alignment of overall treatment
  - increasing the level of TA provision to support countries to address issues identified
  - process of expansion of the new global framework structures to the remaining 3 Regions, and development of performance indicators for assessing the implementation of the new global support framework

## Discussion

The committee accepted the Terms of Reference as presented in the transition plan as well as their dual role.

The committee recognized that while implementing the new global framework changes may become necessary in order to have all means to deliver what needs to be delivered and that the Secretariat is needed to channel the work of the committee as there is no other efficient way.

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The committee agreed that the dual role of the committee can and should be used as a strength as WHO still has some cachet in parts of the world that can be used to move the work while if the committee desires to do something that WHO cannot do, the committee can draw upon the partnership secretariat to do it. The committee called for closer cooperation and communication between the STOP TB partnership and the gGLC Secretariat.

## Conclusions and recommendations

The gGLC endorses

- The Terms of reference for the gGLC as outlined in the transition plan of the new framework
- Its dual role as advisory committee to WHO and partners and commits to use this dual role as a strength
- The decentralization of GLC activities to regions and setting up of rGLCs to work closer with countries, however, urges the regional GLCs to focus on strategic advice and guidance to WHO and partners (adhere to TOR as outlined in transition plan)

## Session 2 - Report from gGLC Secretariat \* rGLCs and other Regional Issues

Objective: To review progress of MDR-TB management scale up in high-burden countries and selected other countries, to identify common major bottlenecks and strategies to address them

Dr Fraser Wares presented on the progress in the scale-up of MDR-TB care and services. The following topics were discussed: data on the 2010 global burden of TB as presented in WHO's 2010 Global TB Report; MDR-TB patient enrolment and target at the global level and in selected countries - China, India and Russian Federation; and an update on WHO policies and guidelines.

The presentation can be found at:

<http://workspace.who.int/sites/PMDT/Global/1stgLC/default.aspx?RootFolder=%2fsites%2fPMDT%2fGlobal%2f1stgLC%2fDocument%2oLibrary%2fi%2fgGLC%2omt&FolderCTID=&View=%7b00154F3F%2d2DA7%2d4E5D%2dA77B%2dC3CFD65D4oFA%7d>

The following questions were raised to the gGLC:

- Does the gGLC agree with analyses presented?
- Which are the “priority areas” where the work of WHO and partners has comparative advantage, and where their efforts should be focused?

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- Should WHO have a follow-up meeting to the 2009 Beijing meeting in 2012 or 2013?
- Should WHO produce MDR-TB Progress Reports annually up to 2015?

### Discussion

The need to focus on certain components in MDR-TB control was discussed. This includes: pediatric MDR-TB, contact tracing, human resource capacity, infection control, treatment for XDR-TB, diagnostic capacity and political commitment. The gGLC recognizes the importance of strengthened advocacy for the scale up of MDR TB management. The MDR-TB Progress Report is an important advocacy tool and helps to maintain MDR-TB visibility.

### Conclusion and Recommendations

The gGLC recommends:

- WHO to produce a yearly MDR TB progress report until 2015 using targets and indicators of the Global Plan as yardstick and the
- STOP TB partnership to develop a Comprehensive advocacy strategy to support the expansion of DR-TB management (as outlined in the transition plan)
- WHO and partners to consider the organization of some kind of a follow up meeting to the high level ministerial meeting in Beijing in 2013, and WHO and partners to present the case at the next gGLC meeting, together with an assessment of the impact of the Beijing meeting
- All partners to make use of available official data available, e.g. in the MDR TB report for advocacy purposes

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Dr Lee Reichman, Chair of the rGLC WPRO, and Dr Andrey Maryandyshev, Chair of the rGLC EURO provided an update from the first WPR and EUR rGLC meeting, respectively. The TOR and the modus operandi were discussed in both meetings. There were two issues raised by the WPR rGLC - sustainability of the rGLC and availability of second-line drugs for MDR-TB treatment.

AFR/EMR/SEAR related issues

Dr Tauhid Islam presented on the common issues in PMDT implementation as raised by AFR, EMR and SEAR. A synopsis of monitoring and TA missions carried out in these three regions was presented. A brief summary including major findings and recommendations of the mission reports for Kenya, Tunisia, Sri Lanka and Timor-Leste were presented.



The presentation can be found at:

<http://workspace.who.int/sites/PMDT/Global/1stGLC/default.aspx?RootFolder=%2fsites%2fPMDT%2fGlobal%2f1stGLC%2fDocument%2oLibrary%2fi%2fgGLC%2omt&FolderCTID=&View=%07b00154F3F%02d2DA7%02d4E5D%02dA77B%02dC3CFD65D4oFA%07d>

The following questions were raised to the gGLC:

- Are you in agreement with the recommendations?
- Any suggestions to specific countries?

## Discussion

The gGLC recognizes that good communication among the rGLCs and the gGLC will be essential to ensure collaboration and consistency among the regions.

It was discussed that in order to provide recommendations for regions currently without rGLCs, there is a need for the gGLC to be provided with a brief summary of the mission carried out within the regions.

## Conclusion and Recommendations

The gGLC recognizes that good communication among the rGLCs and the gGLC will be essential to ensure collaboration and consistency among the regions.

The gGLC recommends:

- The rGLCs and their secretariats to update the gGLC on developments in countries (e.g. through feedback by the chairs and posting of information on the SharePoint).
- The gGLC secretariat to produce a 1 to 2 pages document describing the package of information to be presented to the gGLC at each of their meetings in relation to TA and M&E activities, particularly for the regions currently without rGLC

### Session 3 - Shortened MDR-TB Regimen and Policies on New Drugs

Objective: To provide advice on the collection of evidence for shorter treatment regimens for MDR-TB, and on the introduction of new anti-TB drugs

Dr Ernesto Jaramillo presented: *Shortened (9-12 months) treatment regimens for MDR-TB cases – next steps*

The presentation can be found at:

<http://workspace.who.int/sites/PMDT/Global/1stGLC/default.aspx?RootFolder=%2fsites%2fPMDT%2fGlobal%2f1stGLC%2fDocument%2oLibrary%2ft%2fgGLC%2omt g&FolderCTID=&View=%7b00154F3F%2d2DA7%2d4E5D%2dA77B%2dC3CFD65D4oFA%7d>

The following questions were raised to the gGLC:

- 1) What is the opinion of gGLC on the approach of WHO to support countries and partners building evidence for short MDR-TB treatment?
- 2) What is the opinion of the gGLC on the advice that WHO will give to countries and donors on the use of short term MDR-TB regimens?

### Discussion

In summary, so far there is only one publication on the short course regimen available (observational data from Bangladesh) and the STREAM study will test out the regimens under randomized controlled conditions over the coming years. The Bangladesh TB patient population was quite particular and thus the relevance of findings to other settings, e.g. for settings where co-morbidity of HIV is expected to be higher and/or settings with high % of FLD & SLD resistance cannot be predicted.

The presented study carried out in Cameroon bears the features of an interventional study given that the regimen is not in mainstream use. Moreover there are no controls and no randomization

### Conclusion and Recommendations

The gGLC fully endorses

- the steps that WHO plans to take regarding shortened MDR-TB treatment regimens that are not in line with current WHO policy, that include
  - Advising restriction of use of such shortened regimens to research conditions following international standards (including GCP, DSMB etc.)
  - Provision of technical support to countries to facilitate building the research capacity needed
  - preference to support RCTs that provide the best evidence needed for policy making
  -

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The gGLC acknowledges

- That the Cameroon project is not and has not been an observational study but an intervention study that requires the implementation of the corresponding research standards for a trial; and recommends WHO to assist the country to build the research capacity for proper testing of the regimen

The gGLC supports

- the notion that once satisfactory research conditions are achieved, the WHO should advise the GFATM to support the purchase of the drugs regimens required

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Christian Lienhard, StopTB Partnership, presented on the *Development of policy recommendations for the introduction of new drugs for MDR-TB*.

The presentation can be found at

<http://workspace.who.int/sites/PMDT/Global/1stGLC/default.aspx?RootFolder=%2fsites%2fPMDT%2fGlobal%2f1stGLC%2fDocument%2oLibrary%2fi%2fgGLC%2omt g&FolderCTID=&View=%7b00154F3F%2d2DA7%2d4E5D%2dA77B%2dC3CFD65D4oFA%7d>

## Discussion

“Over the counter” dispensing of TB medicines has been a persistent problem which has proved difficult to control and the gGLC will reflect on possible measures to be taken early on before the new compounds will be released to the market.

## Conclusion and Recommendations

The gGLC acknowledges that

- Two new drugs are likely to be approved for use in MDR-TB in addition to an “Optimized Background Therapy” using currently available second line drugs
- Attempts to limit misuse of new drugs are likely to face the same problems experienced up to now with other antibiotics
- Too much restriction may favour the market for counterfeits
- Countries will need to establish mechanisms to regulate and “protect” the new drugs

The gGLC congratulates

- WHO and the Partnership on the work that has been carried out in relation to development of policy for the introduction of new drugs and looks forward to working with WHO and partners to provide future advice as this work proceeds further.

The gGLC recommends that

- 1-2 gGLC members are part of the Task Force to develop a “roadmap for introduction on new drugs/regimens”

#### **Session 4 - Framework for diagnostic-treatment alignment**

Objective: To provide advice on a framework for the alignment of diagnostic services, treatment management services, and second line drug supplies, and on how to increase the level of TA provision to support countries to address issues identified

Caroline Bogren, Global Drug Facility Manager, presented a *Procurement Analysis –2nd Line Drugs*.

The presentation can be found at

<http://workspace.who.int/sites/PMDDT/Global/1stGLC/default.aspx?RootFolder=%2fsites%2fPMDDT%2fGlobal%2f1stGLC%2fDocument%2oLibrary%2fi%2fgGLC%2omt&FolderCTID=&View=%7b00154F3F%2d2DA7%2d4E5D%2dA77B%2dC3CFD65D4oFA%7d>

In 2010, GDF provided an estimated 10,700 DR-TB treatments to programmes. A limited number of prequalified products are available through a limited number of manufacturers. GDF conducted a meeting with manufacturers in India to better engage with manufacturers. For many manufacturer incentives are insufficient to undergo pre-qualification as they are delivering to sufficient big markets at home (i.e. Indian manufacturers).

CHAI suggests that around 30,000 patient treatments/year would be necessary to render the market sustainable. The private market, if included, could play an important role in price reduction.

#### **Discussion**

Delays with the disbursement of funds from the donors are frequently creating obstacles to timely delivery of second line drugs to countries. The strategic rotating stockpile (SRS) partly helps to cover for delays in fund disbursements, but it is a limited stock and cannot be applied for all countries especially those with larger orders and/or special requirements.

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It was raised that Group V drugs remain partly inaccessible through GDF, e.g. *Clofazimine*, *Linezolid*. The gGLC needs to ensure to clearly communicate which products it would like to see made available through GDF.

### Conclusion and Recommendations

The gGLC recommends

- GDF to go beyond the standard requests for expression of interest and to engage directly and intensely with manufacturers to encourage the manufacture of second-line drugs that meet WHO qualifications. This especially includes all drugs for which zero to one manufacture is producing a quality-assured drugs. It also includes Group V drugs (e.g. Linezolid and clofazimine). A report back to the gGLC on the activities and strategies is requested (and should be part of the normal transparent operations of the GDF).
- WHO to work with the GF to ensure that funds for SLDs should be systematically disbursed directly to the procurement agent, in order to avoid delays incurred with multiple fund transfers and ensure that patients can be put on treatment in a timely fashion (i.e. allow for money to go directly to the procurement agent from the GF for second-line anti-TB drugs for specific countries, rather than having the money pass through the country first).

The gGLC requests

- gGLC Secretariat to summarize the work that has been carried out in relation to Clofazimine and the current situation, and circulate to the gGLC members for further discussion and comment
- That the decentralization of GDF services to the regions be discussed during the next gGLC meeting in February 2012.

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Dr Karin Weyer, WHO STB TBL Coordinator, presented an *Update on scale-up of laboratory services to diagnose drug-resistant tuberculosis*

The presentation can be found at:

<http://workspace.who.int/sites/PMPT/Global/1stgLC/default.aspx?RootFolder=%2fsites%2fPMPT%2fGlobal%2f1stgLC%2fDocument%2oLibrary%2fi%2fgGLC%2omt g&FolderCTID=&View=%07b00154F3F%2d2DA7%2d4E5D%2dA77B%2dC3CFD65D4oFA%7d>

## Discussion

The EXPAND-TB project is working in 25 countries to support and increase laboratory capacity. As of quarter 2 of 2011, multiple partners have out rolled Xpert MTB/RIF to 35 countries. TBL and partners are working on further scale up via UNITAID. The danger of diagnosis outpacing treatment is an opportunity to leverage resources for drugs and treatment services. gGLC members are requested to provide advice on a suitable framework and models for the alignment of diagnostic services, treatment management services, and SLDs.

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Dr Ernesto Jaramillo, WHO STB MDR, provided an *Update on treatment services*.

The presentation can be found at:

<http://workspace.who.int/sites/PMDT/Global/1stgLC/default.aspx?RootFolder=%2fsites%2fPMDT%2fGlobal%2fstgLC%2fDocument%2oLibrary%2fi%2fgGLC%2omt g&FolderCTID=&View=%7b00154F3F%2d2DA7%2d4E5D%2dA77B%2dC3CFD65D4oFA%7d>

Critical challenges to support countries to scale up include:

- A substantial part of patients seek care from providers who do not follow international standards for treatment. Evidence has shown that engaging all providers (through PPM) increases TB notifications. Potentially, a 20-30% increase can be expected if all care providers are engaged. A Task Force for PPM for DR TB has been established to develop a framework for action
- Delays in diagnostic and initiation of treatment means that persons with infectious MDR-TB and XDR-TB remain in the communities for a long time spreading disease.
- Shortage of trained staff to manage MDR-TB cases.

The following advice was requested from gGLC:

- 1) What are the major strategic elements missing from the presented approach to “treatment services”?
- 2) What are the best options for WHO to develop the next steps further?

## Discussion

The need to increase TA was discussed. Even diagnosed DR-TB patients are not started on treatment which suggests a lack of capacity at the country level.

The absence of treatment for patients that have been diagnosed creates an unacceptable ethical dilemma while it may also empower the patient to make important decisions on life and demand treatment. The introduction of Xpert and the increase of diagnosis do not change the situation - it just brings the exiting situation of patients to light. If governments regard the fact that they have patients on waiting lists for treatment as acceptable, advocacy efforts and political pressure must be applied as this is not acceptable.

Some data to align diagnostics and treatments is already available, however the private sector must be urgently included.

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Framework for the alignment of diagnostic services, treatment management services and second line drug suppliers

Objective:

- To highlight the complexities of implementing services and care for MDR-TB patients; and
- To stimulate discussion and seek advice on how to ensure that diagnostic services, treatment management services, and second line drug supplies are aligned in order that all diagnosed MDR-TB cases are placed timely on quality treatment and taken through to cure

Dr Fraser Wares, WHO STB MDR, presented on the *Alignment of diagnostic services, treatment management services, and second line drug supplies*.

The presentation can be found at:

<http://workspace.who.int/sites/PMDDT/Global/1stGLC/default.aspx?RootFolder=%2fsites%2fPMDDT%2fGlobal%2f1stGLC%2fDocument%20Library%2f%2fgGLC%20mtg&FolderCTID=&View=%2f7b00154F3F%2d2DA7%2d4E5D%2dA77B%2dC3CFD65D40FA%7d>

The following *Next steps* were proposed:

- To understand what the critical steps are from decision making to implementation and how to build in particular in-country managerial and treatment management capacity, with identification of enabling factors:
  - Commission country case studies; and
  - Learn from the scale up of other TB initiatives, e.g. EXPAND TB
- Co-ordination of the provision of TA as per country need to build in-country management capacity
- Establishment of consortium of technical and implementing agencies to:

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- i. develop proposal for SLDs to UNITAID using the opportunity of LoI call for diagnostics to leverage resources for drugs and treatment services; and
- ii. develop proposal/package to build in-country managerial and treatment management capacity

The following questions were raised to the gGLC members:

- Are there any major strategic elements missing from this approach to “alignment of diagnostic, SLDs and treatment management”?
- How should WHO further develop the next steps under consideration?
- What are the options that WHO and partners should consider to make optimal use of the resources available to support countries to ensure alignment of services?
- What are the “bottlenecks” where the work of WHO and partners have comparative advantage, and should focus their efforts?
- What lessons should WHO and partners learn from the scale up of other health programmes, as well as other TB initiatives?

## Discussion

It was proposed that existing concepts like EXPAND TB/FIND model could be followed to link all components (diagnosis, drugs and treatment capacity). A hand book focusing on clinical and managerial aspects (*how to*) may be helpful to align the essential components at the country level. Guidelines for Community based MDR treatment are under development and may cover many of the managerial aspects

A country by country analysis addressing identified issues (as in the EXPAND TB model) was felt to be helpful. The possibility was discussed to organize meeting back to back with the GLI meeting in Annecy, France and/or the UNION meeting in Kuala Lumpur, Malaysia to bring various stakeholders at one table and coordinate planning.

## Conclusion and Recommendations

The gGLC recognizes

- The crucial importance of building capacity in countries for the alignment of diagnostic services, second line drug supplies and treatment services to ensure timely diagnosis and initiation of quality treatment of MDR-TB patients and support through to cure

The gGLC recommends WHO to

- draft a “framework for MDR TB” document on the linkage of diagnosis, drugs and treatment services using the model presented by Expand TB/GLI
- carry out selected country case studies to analyse operational planning, identification of bottlenecks and solutions



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- organize meetings in 2012 of countries and technical partners to develop coordinated plans for MDR-TB scale-up, and to review current activities to strengthen co-ordination of technical assistance. These meetings could be organized in conjunction with the GLI meeting in Annecy, April 2012, and by a proposed MDR-TB working group meeting during the UNION conference, November 2012.
- To ensure that the “Companion manual” to the WHO 2011 update of the PMDT guidelines covers step-wise the ‘how to do’ elements to plan and implement PMDT activities, and can serve as a practical guideline to NTP Managers on how to start PMDT activities

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Dr Tauhid Islam, WHO STB MDR, presented on *How to increase the level of TA provision, including provision of early TA in to the GF processes / Guidance on planning MDR-TB component of the national tuberculosis control programme.*

The presentation can be found at:

<http://workspace.who.int/sites/PMDT/Global/1stGLC/default.aspx?RootFolder=%2fsites%2fPMDT%2fGlobal%2f1stGLC%2fDocument%20Library%2ft%2fgGLC%2omt g&FolderCTID=&View=%2f7b00154F3F%2d2DA7%2d4E5D%2dA77B%2dC3CFD65D4 oFA%7d>

### Conclusion and Recommendations

The gGLC recognizes the importance of human resource development for PMDT scale up.

The gGLC recommends:

- WHO and partners to establish an international consortium of all the major stakeholders to address:
  - The supply of TA, coordinate their approaches, address who takes the lead in individual countries
  - How to make full use of existing capacity within countries for technical assistance where possible e.g. Universities to set up knowledge hubs
  - The use of modern communication and training technologies to build in-country capacity of human resources for PMDT
  - The development of an online training course on PMDT

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- The international community fulfil the aspirations made in the transition plan for the new global support framework to establish in-country long term PMDT related advisor (implementing) positions. These positions need not always be WHO employed positions, but could be funded positions to the NTP, seconded positions by WHO or partner organizations to the NTP, or dedicated NGO staff working in advisor/implementing positions in country.
- WHO to consider employing dedicated officers for MDR-TB at country level in key countries (in addition to having an advisor/implementing positions)
- gGLC Secretariat and partners to organize in early 2012 a meeting of stakeholders in the provision of technical assistance for MDR-TB control

The gGLC recommends

- WHO to prioritize countries for the provision of TA to focus on scale up of MDR TB management (e.g. based on burden of disease, "big countries with big problems", existence of political will, facilitating setting etc.)

The gGLC requests

- The Secretariats to prepare a paper defining the criteria to be used for prioritization and to outline specific models of TA for consideration for consideration of endorsement by the gGLC.

The gGLC

- Should continue to review and advise on proposed models for TA and coordination
- Should play a part in recognizing the efforts made by countries to scale up MDR TB management
- To review and provide feedback on the presented planning tool by 30 November 2011

## Session 5 - Expansion of the new framework

Objective: To advice on the development of performance indicators for assessing the implementation of the new global support framework and on how to expand to the remaining 3 Regions

1. Expansion of the functions of the new global support frame work to the remaining 3 Regions

## Conclusion and Recommendations

The gGLC recommends:

- That the decentralization to the remaining 3 regions (AFR, EMR & SEAR) should be done as soon as possible, and that
- The secretariats of these three rGLC should be housed in WHO regional offices and consequently there should be no competitive bidding
- That all rGLC secretariats be staffed with experienced personnel in the scale up of PMDT and be adequately supported by regional WHO offices to fulfil the ToR of the New Framework.

The gGLC recognizes:

- That some regions may need additional personnel beyond the proposed two member rGLC secretariat described in the New Framework.
- That it has a role to play in monitoring of the work of the rGLCs

The gGLC agrees that Dr Aamir Khan, as the Chair of the MDR TB working group, will participate in the gGLC meetings as an ex-officio member of the gGLC.

## Other business

The gGLC requests

- That the outcomes of the 1st gGLC meeting to be discussed at the meeting of the core group of the STP's MDR-TB Working Group during the UNION conference in Lille, France, Oct 2011.
- The 2nd gGLC meeting will take place on 28th and 29th February 2012.

The Chair thanked the participants and closed the meeting.

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**Annex 1 – Agenda Day 1 (6 October 2011)**

09.00 – 09.30	Welcome of participants  Declaration of Conflict of Interest	Mario Raviglione & Lucica Ditiu/Aamir Khan  Chair (CD) / Secretariat (FW)	
<b>Session 1</b> 09.30 – 10.30	Objective: To orientate gGLC members on the new global framework to support expansion of MDR-TB care and services, and the role and function of the gGLC in the framework  Overview of the new global framework to support expansion of MDR-TB care and services  Presentation of the TOR for the gGLC and the gGLC Secretariat, and objectives of the meeting	MDR/GLC Unit (PN)  Secretariat (FW)	Rapporteur  SC
<b>10.30 – 11.00 Coffee</b>			
<b>Session 2</b> 11.00 - 13.00	Objective: To review progress of MDR-TB management scale up in high-burden countries and selected other countries, to identify common major bottlenecks and strategies to address them  Report from the gGLC Secretariat: <ul style="list-style-type: none"> <li>Policy updates, progress versus targets in the Global Plan, updates from WHO 2011 MDR-TB Progress Report and Annual Global TB Report</li> </ul> Feedback from AMR, EUR and WPR rGLCs, and issues identified  AFR/EMR/SEAR related issues <ul style="list-style-type: none"> <li>Synopses of monitoring and TA mission reports prepared and presented to gGLC by Secretariat</li> <li>Major common issues noted from monitoring and TA mission reports</li> </ul>	Secretariat (FW)  AMR rGLC (JCL), Chair EUR rGLC (AOM), Chair WPR rGLC (LBR)  Secretariat (TI)	Rapporteur  AB
<b>13.00 – 14.00 Lunch</b>			
<b>Session 3</b> 14.00 – 15.30	Objective: To provide advice on the collection of evidence for shorter treatment regimens for MDR-TB, and on the introduction of new anti-TB drugs  Shortened (9-12 months) treatment regimens for MDR-TB cases – next steps	MDR/GLC Unit (EJ)	Rapporteur  DF
<b>15.30 – 16.00 Coffee</b>			
<b>Session 3 continued</b> 16.00 – 17.00	Policy on introduction of new drugs for MDR-TB	STP (CL)	Rapporteur  DF
17.00 – 17.30	Wrap up Day 1	Chair (CD)	

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Day 2 (7 October 2011)

<b>Session 4</b> 09.00 – 10.30	Objective: To provide advice on a framework for the alignment of diagnostic services, treatment management services, and second line drug supplies, and on how to increase the level of TA provision to support countries to address issues identified  Update on scale-up of laboratory services to diagnose DR-TB (a)  Update on second-line anti-TB drug market (b)  Update on treatment services for DR-TB cases (c)	GLI/TBL (KW)  GDF (CB)  MDR/GLC Unit (EJ)	Rapporteur  AJ
<b>10.30 – 11.00 Coffee</b>			
<b>Session 4 continued</b> 11.00 – 13.00	Framework for the alignment of diagnostic services, treatment management services, and second line drug supplies (a / b / c)	Secretariat (FW)	Rapporteur  TI
<b>13.00 – 14.00 Lunch</b>			
<b>Session 4 continued</b> 14.00 – 15.00	How to increase the level of TA provision, including provision of early TA in to the GF processes / Guidance on planning MDR-TB component of the national tuberculosis control programme	Secretariat (TI)	Rapporteur  AB
<b>Session 5</b> 15.00 – 15.30	Objective: To provide advice on: a) expansion of the functions of the new framework to the remaining 3 Regions; and b) assessment of the implementation of the new global support framework  Expansion of the functions of the new global support framework to the remaining 3 Regions	Secretariat (FW)	Rapporteur  AB
<b>15.30 – 16.00 Coffee</b>			
<b>Session 5 continued</b> 16.00 – 17.00	Assessment of the implementation of the new global support framework	Secretariat (SC)	Rapporteur  AB
17.00 – 17.30	Next steps and closing	Chair (CD)	

## Annex 2 - List of participants

### gGLC Members

1. **José Caminero Luna** (also designated representative, AMR rGLC)  
**(UNABLE TO ATTEND)**  
Consultant  
IUATLD Servicio de Neumologia  
Hospital de Gran Canaria "Dr Negrin"  
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2. **Lucy Chesire**  
Executive Director  
TB ACTION Group  
Ambassador Court, Block A 5  
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KENYA
3. **Dr Chen-Yuan Chiang**  
**(UNABLE TO ATTEND)**  
Director  
Department of Lung Health and NCDs  
International Union Against  
Tuberculosis  
and Lung disease (The Union)  
68, bd Saint-Michel  
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FRANCE
4. **Daniela Maria Cirillo**  
Head, Emerging Bacterial Pathogens  
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San Raffaele Scientific Institute  
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5. **Charles Daley**  
Division of Mycobacterial and  
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Infections  
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6. **Joel Keravec**  
Projeto MSH – Programa RPM Plus -  
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Management Sciences for Health  
Rational Pharmaceutical Program  
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Rio de Janeiro  
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7. **Mr Neeraj Mohan**  
**(UNABLE TO ATTEND)**  
Vice President of Market Dynamics and  
New  
Initiatives  
Clinton Health Access Initiative Inc.  
(CHAI)  
383 Dorchester Ave, Suite 400  
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UNITED STATES OF AMERICA
8. **Michael Rich**  
Instructor & Associate Clinician  
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Medical School  
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9. **Dr Hind Satti**  
Clinical Director  
Partners In Health  
Corner of Lancers and Caldwell Street  
Maseru West  
Maseru 100  
LESOTHO
10. **Andrey Olegorich Maryandyshev**  
Chair, GLC\Europe  
Head of the phthisiopulmonology  
department  
Northern State Medical University,  
Troitsky 51,  
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RUSSIAN FEDERATION

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**11. Lee B. Reichman**

Chair, WPR rGLC  
Executive Director  
New Jersey Medical School Global  
Tuberculosis Institute (UMDNJ)  
PO Box 1709  
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**Observer**

**12. Aamir Khan**

Chair MDR-TB Working Group  
Director  
MDR-TB Control Program  
The Indus Hospital  
Korangi Crossing  
75190 – Karachi  
  
PAKISTAN

**WHO Headquarters**

- 13. Mario Raviglione, Director, STB
- 14. Paul Nunn, Coordinator, STB/MDR
- 15. Karin Weyer, Coordinator, STB/TBL
- 16. Angelito Bravo, STB/MDR
- 17. Susanne Carai, STB/MDR
- 18. Tauhid Islam, STB/MDR
- 19. Aziz Jafarov, STB/MDR
- 20. Ernesto Jaramillo, STB/MDR
- 21. Fraser Wares, STB/MDR

**Stop TB Partnership**

- 22. Lucica Ditiu, Executive Secretary,  
TBP
- 23. Caroline Bogren, Manager, GDF
- 24. Christian Lienhardt, TB