

GLOBAL DRUG-RESISTANT TB INITIATIVE (GDI)

CONCEPT NOTE

I. Rationale for restructuring the Stop TB Working Group on MDR-TB and its global Green Light Committee subgroup

Drug-resistant tuberculosis (DR-TB), particularly multi-drug resistant tuberculosis (MDR-TB) and extensively drug resistant tuberculosis (XDR-TB), represent significant threats to global TB control efforts and a major public health concern in several countries. Levels of MDR-TB remain worryingly high in some parts of the world, notably countries in Eastern Europe and Central Asia. In several of these countries, up to 32% of new cases and more than 50% of previously treated cases have MDR-TB. Globally, just 19% of the cases of MDR-TB estimated to exist among all notified patients with pulmonary TB were reported to WHO in 2011. An even smaller proportion received treatment of known quality with quality-assured second-line drugs. The Global Plan target of at least 75% treatment success among enrolled MDR-TB patients by 2015 has so far been reached by only 30 of 107 countries that reported treatment outcome data for patients with MDR-TB in 2011. The global statistics on enrolment and treatment outcome of MDR-TB cases therefore necessitate an urgent response for scaling up access to DR-TB services.

While TB diagnostics are making fast strides due to innovation and technological advances, there are still major gaps in the capacity to deliver high-quality MDR-TB care in many countries. As a result many patients, even after being diagnosed as MDR-TB, do not get enrolled for treatment, increasing both mortality and the transmission of resistant strains. A concerted global response involving all stakeholders is essential to address this emerging problem, and means that efforts to control DR-TB can no longer go on with 'business as usual'. This was reiterated during the recent joint meeting of the core group (CG) of the MDR-TB Working Group (WG) and the global Green Light Committee (gGLC) in April 2013. The meeting passed a unanimous resolution to restructure and revitalize the current functioning of the Working Group and its sub-groups to make it more responsive to current needs, and efficient and effective in its activities.

Background

To support scale-up towards universal access to quality treatment of MDR-TB, a new Global Framework was developed and launched in 2011 following an inclusive process undertaken by key stakeholders supporting the expansion of MDR-TB services and care. The main focus of the new Framework was increased on-site, long-term technical support to countries through decentralized structures. As a first step towards operationalizing this strategy, regional Green Light Committees (rGLCs) in all 6 WHO regions with secretariats hosted by WHO regional offices, have now been established.

Therefore, it is considered an ideal time to build on the current mechanisms and reinvigorate efforts for universal access to MDR-TB diagnostic and treatment services as envisaged in the 62nd World Health Assembly (WHA) resolution on Prevention and control of MDR-TB and XDR-TB (WHA62.15)¹ and fully align with the vision and objectives of the Stop TB Strategy and targets of the Global Plan to Stop TB 2011-15², through a collective partnership effort. The restructured Stop TB Working Group would be an inclusive group assisting countries and their partners to

¹ http://apps.who.int/gb/ebwha/pdf_files/WHA62-REC1/WHA62_REC1-en-P2.pdf

² http://www.stoptb.org/assets/documents/global/plan/TB_GlobalPlanToStopTB2011-2015.pdf

overcome the constraints to universal access to PMDT services whilst providing a flexible and representative platform for co-ordination of global technical assistance and advocacy efforts at all levels. A new name for the Working Group is proposed to reflect these activities, ie. the Global Drug-resistant TB Initiative (GDI).

II. Mission statement

The mission of the GDI is to serve as a multi-institutional, multi-disciplinary platform organizing and coordinating the efforts of stakeholders to assist countries to build capacity for programmatic management of DR-TB (PMDT). The ultimate aim is to ensure universal access to care and appropriate treatment for all DR-TB patients. The group will mobilize resources and undertake activities to ensure a holistic, quality-assured, patient-centred approach for all DR-TB patients within the existing TB care structures of the country.

The GDI will have the following strategic priorities:

- Global guidance on appropriate management of DR-TB and best practices in patient-centred care delivery in accordance with international best practices;
- Technical advice to facilitate patient access to high-quality DR-TB care through a long-term, in-country capacity building approach;
- Appropriate integration and coordination of efforts by multiple partners to align diagnostic services for patients and access to high-quality care;
- Coordination of technical assistance and effective knowledge sharing among partners;
- Strengthened regional frameworks and collaboration with of rGLCs for support to country level PMDT activities
- Development of targeted advocacy strategies and resource mobilization for DR-TB management scale-up;
- Prioritization of human resource development and training, including development of comprehensive training and retention strategies, and proposals to train different cadres of PMDT consultants from developing countries.

GDI provides the necessary umbrella structure to facilitate integration, partnership building, and coordination of activities. As an initiative with broad-based multi-institutional and multi-sectoral membership (with core secretariat functions provided by WHO), it is expected to be in a position to influence and facilitate the much needed integration and sustainability of DR-TB care as part of overall health systems strengthening, both at global and country level. Accordingly, the GDI will undertake the following functions:

- a. Develop a strategic agenda, including research, a work plan and an estimate of resource needs for activities in priority areas and in the framework of the Partnership;
- b. Provide a coordination mechanism for the implementation of policies and activities agreed by the Partnership and approved by the Coordinating Board through a core group (CG) (the constitution and functions of the Core Group are described in section VI);
- c. Act as a consensus-building mechanism in support of the development of new technical standards where appropriate and advise on development of overarching policies that involve multiple sectors and partners;
- d. Serve as a mechanism for developing broad global consensus, unifying strategies, objectives and priorities and monitoring global PMDT efforts based

- on the reports generated by the Global TB Programme of WHO as well as country specific feedback from TB program managers and partners received during meetings and workshops, and research activities;
- e. Participate in developing and implementing approaches to communications, resource mobilization and advocacy for PMDT;
 - f. Report to the Partnership Coordinating Board at each formal Board session on plans and progress towards reaching PMDT targets.

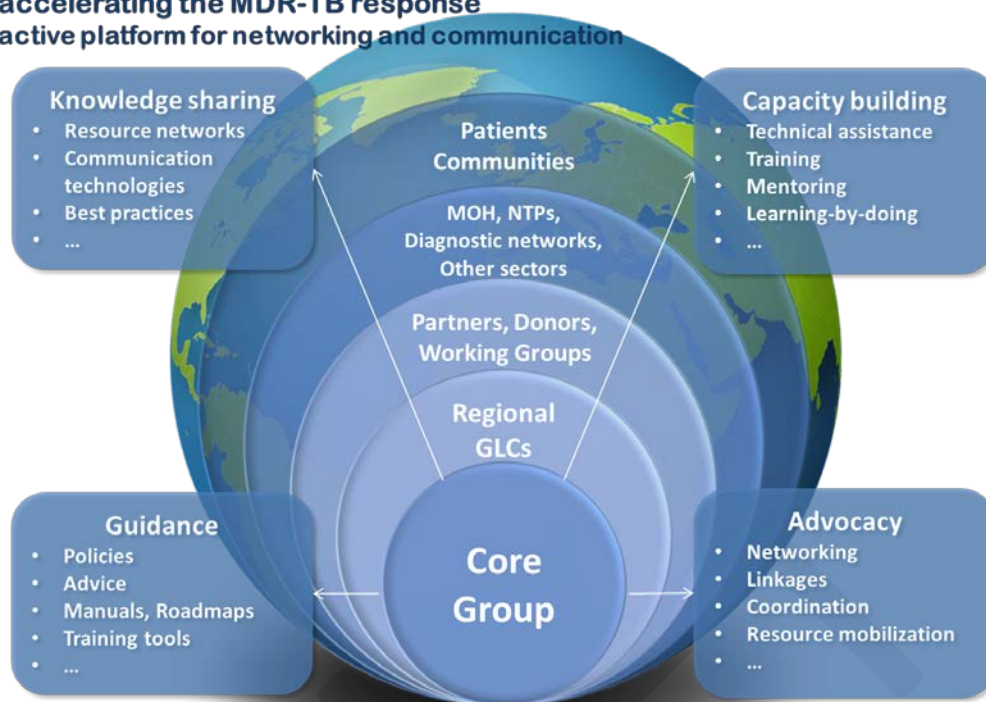
III. Terms of Reference

Terms of reference for the GDI include the following:

- Support the development of guidelines and evidence-based policies, norms and standards;
- Maintain the GDI Secretariat and facilitate coordination of partner technical assistance;
- Promote communication and coordination among Stop TB Partnership Working Groups and members, and across WHO Departments on drug-resistant TB related issues;
- Provide global and regional analysis on progress in DR-TB scale-up;
- Promote DR-TB related TB advocacy activities, resource mapping and coordinated resource mobilization;
- Defining the research agenda including operational research for introduction and roll-out of new policies, new tools and recently approved drugs for management of DR TB cases;
- Guide ad-hoc, need-derived task groups constituted with different partners as leads for various thematic areas of work.



GDI - Global Drug-resistant TB Initiative
accelerating the MDR-TB response
active platform for networking and communication



IV. Structure and Relationships

Organizationally, the **GDI** shall continue to be one of the Working Groups of the Stop TB Partnership.

Functionally, the **Core Group of the GDI (hereafter CG)** represents the members of the initiative to the Coordinating Board of the Stop TB Partnership, WHO, partner organizations, development and funding agencies, WHO member states, and private sector entities providing care to patients with DR-TB.

Structurally, the **CG** consists of individuals with expertise in multiple disciplines representing constituencies, stakeholders, and institutions participating in the Stop TB Partnership, and involved in global and country-level improvement and scale-up of programmatic management of DR-TB.

The **GDI Secretariat (hereafter Secretariat)** will continue to be provided by the Laboratories, Diagnostics and Drug Resistance (LDR) Unit of the WHO Global TB Programme and hosted in the WHO Headquarters in Geneva.

The CG will convene activity- or project specific, time-limited task forces to undertake specific tasks. The members of such technical groups will be selected from within the overall Working Group partners and assigning a lead partner. The CG will undertake at least one mid-term review and one end-of-term review of activities undertaken by these technical groups. Products/deliverables of these groups will be presented to the GDI Working Group during annual meetings.

GDI: structure and governance

WHO Global TB Department
GDI secretariat

Stop TB Partnership Working Group

GDI Core Group
Guides, approves, evaluates Projects/Activities
Advises secretariat and partners

Task force/s

Project/Activity 1
eg. Aligning diagnosis and treatment

Project/Activity 2
eg. Drug-resistance research agenda

Project/Activity 3
eg. Electronic recording and reporting

Project/Activity 4

Project/Activity 5

Project/Activity 6

- Priority projects/activities
- Partner approach
- Time-limited
- ...

V. Ethical considerations and conflicts of interest

CG members are expected to declare any conflicts of interest, either relating to the issues discussed during the meetings or to prior or current direct involvement in implementation of strategies to be recommended by the GDI. Should any member declare a possible conflict of interest, the relevant member may be asked by the Chair or his/her delegate to refrain from the particular discussion and will not be allowed to vote on the specific decision.

Independent experts outside the CG who are consulted in connection with a specific issue will be required to sign the same declaration of interest documents.

VI. Membership

GDI membership will be open to members of the Stop TB Partnership, and include members from a wide variety of professional organizations, institutions, medical associations, national TB programmes, technical partners, civil society organizations and NGOs.

Key constituencies for GDI include:

- Technical partners
- Civil society
- Regional Green Light Committees
- Donor/funding agencies
- National TB programmes of high burden DR-TB countries
- Implementation partners assisting NTPs of high burden DR-TB countries
- The Global Laboratory Initiative
- National/international/scientific/professional medical associations and nursing associations or other institutions of high scientific and technical standing having attained international recognition in the area of DR-TB management;
- Regional or country centres of excellence in programmatic management of DR-TB and/or other collaborative networks carrying out activities in support of PMDT.
- Academic institutions
- Private sector and non-governmental sector partners

Liaisons from other WGs of the Stop TB partnership may be invited as observers to the GDI CG meetings. GDI Liaisons to other implementation WGs will be selected from the CG members by consensus.

CG members have to be able and willing to devote time to the activities related to the GDI.

The WHO Global TB Programme hosts the Secretariat of the GDI. The chairs of the rGLCs will be represented on the CG.

CG membership rests with experts that represent institutions, constituencies, and stakeholders. Membership to the CG will be limited to a maximum of 20 members and based on specific programmatic, clinical, scientific and managerial expertise, while ensuring that patient and community needs are not overlooked. A balance in the CG membership will be sought to encourage participation of and representation from technical partners, civil society, relevant funding agencies with global outreach,

and high MDR-TB burden countries¹. To promote broad representation, the number of CG members from a single organization, institution or constituency may be limited.

An open call for nominations will be widely disseminated by the Secretariat whenever a vacancy occurs or is anticipated within the CG. Interested parties may nominate other members or themselves for the open position by submitting the individual's Curriculum Vitae, a letter of motivation from the nominee, and a letter from the individual's institution supporting participation on the CG. The Secretariat, the chair and two CG members will constitute the committee that will short-list candidates and obtain written confirmation that nominees are able and willing to meet the expectations for CG membership. Voting from the GDI Working Group (through confidential ballot using a secure web-based electronic voting tool) will select the new CG members from the short-list of candidates.

The term of membership in the CG will be two years, with the opportunity for renewal for a second consecutive term of two-years. Selection of a new member and renewal of membership will require approval by the majority of current members of the CG.

Selection of a new CG member will take place at the meeting preceding the end of the term of the individual rotating off the CG. The departing member may participate in the voting. In cases of renewal for a second term, a request for renewal will be announced by the member one month before the next CG meeting, during the actual term, so as to allow sufficient time for the rest of the members to consider the renewal request during the relevant CG meeting.

A previous member may be a candidate for selection to the CG after a lapse equal to at least one term, i.e. after an interruption of two years.

VII. Responsibilities of CG members

Members of the CG are expected to attend all CG meetings and participate in all CG decisions. If attendance by the CG member is not possible, the CG member can nominate a proxy to attend. To fulfil the desired tasks, the members need to be familiar with the primary guiding documents on GDI policies and procedures, and familiar with the global, Stop TB Partnership, WHO and public health context in which the GDI operates, including the main partners and their guiding policy and position statements.

Through the CG, the members are expected to

1. Strengthen GDI processes by contributing to related policies and procedures;
2. Identify current bottlenecks and challenges in PMDT expansion and provide recommendations to WHO and partners on the way forward;
3. Share relevant technical experience and needs from respective constituencies to guide policy making process;
4. Participate and contribute equally in the CG activities. If necessary, outside expert advice may be sought by individual CG members; however, external input must be agreed to by the CG and channelled through the actual CG member;
5. Periodic review of activities of the GDI and the task forces vis-à-vis the strategic plan of the GDI WG;
6. In coordination with the Secretariat, prepare an annual report of activities.

¹ All possible efforts will be made in ensuring gender and geographical balance in country representation.

VIII. CG Chairperson

A specific individual, not an organization or institution, will be elected to be the chairperson from among the CG members. The Chair serves for a two-year term with an option of one renewal for the same duration if supported by a two-third majority of CG members. The term of the Chair will be independent of his/her term as a CG member.

Three months before the end of the chair's term, the current chair with the assistance of the Secretariat will call for nominations. Candidates for the chair are nominated by the CG members from among the current CG.

Responsibilities of the Chairperson

1. To steer the work of the CG and to help assure that all GDI communication, processes, activities, and decisions are carried out accurately and efficiently;
2. To work with the Secretariat to oversee and plan the CG activities;
3. To chair the CG meetings, and oversee the reporting of recommendations and decisions emerging from the meetings;
4. To represent or nominate a CG member to represent the GDI and its interests to external partners, at meetings and national, international, or regional forums when necessary;
5. To represent or nominate a CG member to represent the GDI in the other WGs of the Stop TB Partnership when necessary;
6. To attend the Stop TB Partnership Coordinating Board meeting if required;
7. To attend WHO Strategic and Technical Advisory Group meetings if required.
8. To nominate a vice-chair from the current CG membership.

IX. CG Vice-Chairperson

A specific individual, not an organization or institution, will be nominated by the chair to be the vice-chairperson. The Vice-Chair serves for a two-year term with an option of one renewal for the same duration if supported by a two-third majority of the CG members.

Responsibilities of the Vice-Chairperson:

1. To steer the work of the CG and to help assure that GDI communication, processes, activities, and decisions are carried out accurately and efficiently;
2. To assume and undertake the responsibilities of the Chair of WG in his/her absence
3. To work with the Secretariat to oversee and plan the CG activities.

X. Secretariat

The Secretariat is hosted and appointed by the WHO Global TB Programme in Geneva.

Responsibilities of the Secretariat

1. To communicate with the GDI members on behalf of CG;
2. To plan, coordinate and participate in all official CG meetings; record minutes of the meetings and CG decisions for future reference and follow-up;
3. To facilitate communication with countries in close collaboration with WHO Regional Offices;

4. To maintain the GDI website;
5. To provide regular updates on GDI related processes to the CG members;
6. To manage the GDI budget and financial reporting to donors.

XI. CG decision-making

All decisions are based on **consensus** with a possibility for majority voting as a measure in the situations where consensus cannot be reached.

XII. Meetings

Meetings of the CG take place every 3 months. The CG meets either by teleconference, video conference with at least two face-to-face meetings per year¹.

Ad hoc meetings of selected members to address special topics may be convened by the GDI chair or Secretariat when required.

GDI matters may require additional consultation and correspondence which will be pursued on an on-going basis through email, teleconferences, and other means of communication.

In general, **CG meetings are limited to CG members only**. However, consultants, trainees, and selected observers may attend meetings of the CG by invitation and concurrence by the GDI chair but may not participate in CG deliberations.

XIII. Communication of CG deliberations and review outcomes

The CG will communicate its findings, deliberations and decisions through the Secretariat.

XIV. Financing of the GDI

The Stop TB Partnership, WHO and member organizations may raise funds to sustain the work of the GDI, in accordance with WHO established policies and principles, from national and government-supported agencies, regional and international organizations, non-governmental organizations, universities, research institutions and other sources. Available funds will be used for convening meetings of the GDI and its CG, supporting work of the secretariat, participation of member institutions, and monitoring/evaluation of the activities approved by the GDI.

Funding for technical activities will be managed by different partner organisations taking lead for the purpose within the task specific group created amongst the GDI members.

XV. Changes in governance and operating procedures

The governance and operating procedures can be amended by the CG. Amendments may be voted on at any meeting of the CG, by e-mail or telephone. To be adopted, an amendment must be approved by at least 2/3 of the CG members.

¹ Subject to availability of funds