

SCALING-UP EFFECTIVE MANAGEMENT OF DRUG-RESISTANT TUBERCULOSIS

INFORMATION NOTE

Scaling-up effective management of drug-resistant tuberculosis

Introduction

The Stop TB Partnership has developed a new framework to support the scale-up of effective management of drug-resistant tuberculosis (TB). This document outlines the implications of this new framework for Global Fund TB proposals in Round 11 that include a component on multidrug-resistant TB (MDR-TB). The new framework includes changes to the Green Light Committee (GLC).

Major progress has been made toward achieving global control of TB over the past two decades. However, this progress is being threatened by the spread of MDR-TB (i.e. TB resistant to at least isoniazid and rifampicin), including extensively drug-resistant TB (XDR-TB) (i.e. MDR-TB that is also resistant to a fluoroquinolone and at least one of the three injectable second-line drugs). These forms of TB are more difficult and costly to diagnose, treat and cure. MDR-TB is particularly harmful for people living with HIV. In 2008, the World Health Organization (WHO) estimated that there were 440,000 cases of MDR-TB globally - with 85 percent of the global burden occurring in 27 high-burden countries.

The number of patients with MDR-TB enrolled on treatment in projects or programs approved by the GLC has increased but remains a small fraction of the total estimated number. In 2009 only 24,511 (10 percent) of the estimated 250,000 MDR-TB cases among notified TB cases in the high MDR-TB burden countries were enrolled on treatment, as were 30,475 (11 percent) of the 280,000 cases globally. There is an urgent need for dramatic scale-up of access to effective MDR-TB management. The Global Fund has a key role to play in meeting this need.

Current Global Fund policy on the Green Light Committee (GLC) and Global Drug Facility (GDF)

WHO and the Stop TB Partnership have been supporting countries to manage MDR-TB through the Green Light Committee (GLC). In recognition of the package of services for MDR-TB control provided by the GLC, in 2002 the Global Fund Board¹ decided that Principal Recipients of grants would be required to procure second-line TB drugs through the GLC.²

¹ <http://www.theglobalfund.org/en/board/meetings/third/>

² http://www.stoptb.org/gdf/drugsupply/drugs_available.asp

In 2006 the Global Fund Board further determined that countries whose proposals included funding for MDR-TB control must include provision to share the cost of the GLC Initiative.³ A cost-sharing element (CSE) was introduced in all grants with MDR-TB components from Round 6 onwards, as a flat rate fee not exceeding US\$ 50,000 per grant per year of grant implementation.

The new Stop TB Partnership framework for scaling-up effective MDR-TB management

In response to the urgent need to scale-up access to effective MDR-TB management, the Stop TB Partnership has developed a new global support framework aimed at increasing access to quality-assured second-line drugs and providing better and more extensive technical assistance. Preventing the emergence of XDR-TB depends on ensuring the procurement and use of quality-assured second-line drugs in high quality, effective MDR-TB programs.

The main features of the new framework include the following:

- A focus on building national capacity to scale-up effective MDR-TB management.
- More effective, efficient and extensive provision of technical assistance.
- Direct access to the Global Drug Facility (GDF).
- Advocacy to ensure that countries honor their commitments to achieving universal access to effective management of MDR-TB, including XDR-TB.⁴
- Significant changes in the GLC, with direct access to the GDF.

The new framework came into effect on 1 July 2011.

Proposed changes in the Green Light Committee (GLC) and access to GDF

- Establishment of a global GLC (gGLC) (hosted by WHO in Geneva) to advise WHO and other partners and provide global strategic direction.
- Establishment of regional GLCs (rGLCs) (hosted in the WHO regional offices or by other members of the Stop TB Partnership) to oversee the provision of regional technical assistance.
- Requests by applicants for quality-assured second-line drug procurement and supply from the GDF directly.
- Review of national MDR-TB management expansion plans at the time of grant negotiation.

Interim arrangements

The current agreements regarding the GLC between the Global Fund and WHO (acting for the benefit of the Stop TB Partnership) remain in force until formally replaced by new arrangements. The cost-sharing element for technical assistance therefore remains until a new agreement comes into force. Each applicant whose proposal includes funding for MDR-TB control should select the "Yes" box in Section 6.3 of the application form indicating that US\$ 50,000 per year over the full grant term is to be included in the detailed budget. These funds are the cost-sharing element (CSE) for GLC and so are not available for implementation activities.

³ <http://www.theglobalfund.org/en/board/meetings/thirteenth/>

⁴ <http://www.who.int/mediacentre/events/2009/wha62/en/index.html>

Technical assistance to support proposal development on MDR-TB

Applicants should contact the gGLC Secretariat at glc_secretariat@who.int for information on technical assistance to support Round 11 proposal development on MDR-TB. The Technical Review Panel has highlighted the importance of technical assistance in developing proposals on MDR-TB, ensuring implementation of technically sound activities, and monitoring their quality (e.g. as indicated by treatment outcomes). In its report on Round 10 proposals, the Technical Review Panel noted that "in many proposals the approach to screening and follow-up of MDR-TB patients was not sufficiently described".⁵ It recommended that technical partners work with applicants for Round 11 to ensure that these issues are adequately addressed. In addition, applicants should include in their proposal budgets any technical assistance that may be required to implement MDR-TB related activities during the grant lifetime.

Incorporating MDR-TB activities in Global Fund proposals

1. Scaling up access to effective management of MDR-TB as part of a national TB plan

Good basic TB control is essential to prevent MDR-TB. Applicants are therefore strongly encouraged to submit a National TB Strategic Plan, which incorporates a component on MDR-TB. This MDR-TB component should provide a detailed description of MDR-TB activities, budgets and indicators. In line with the new framework, countries should develop a national plan for scaling up towards universal access to effective management of MDR-TB by 2015, as part of their overall national TB plan.

2. Internationally recommended MDR-TB interventions

International guidelines promote the integration of services for basic TB control and for MDR-TB within a single framework. This approach consists of an essential core of five components that are based on fundamental principles of TB control and flexible options for country-specific implementation. The core components are comprehensive, ensuring that all essential elements of MDR-TB treatment are included. The design and implementation may vary from one country or region to another depending on the local situation. These core components are:

- a) sustained political commitment;
- b) appropriate case-finding strategy including access to quality-assured culture and drug susceptibility testing (DST);
- c) appropriate treatment strategies that use second-line drugs under effective case management conditions;
- d) uninterrupted supply of quality-assured second-line TB drugs; and
- e) a recording and reporting system designed for MDR-TB control programs that enables the monitoring of performance and the evaluation of treatment outcomes.

The WHO "Guidelines for the Programmatic Management of Drug-Resistant Tuberculosis" and its update in 2011 provide guidance on recommended interventions that countries should implement, including surveillance, prevention, diagnosis and treatment, and care and support activities.^{6 7} Applicants should work with partners such as WHO to determine which activities to prioritize and include in their proposals, based on the country context.

⁵ http://www.theglobalfund.org/documents/board/22/BM22_13trpround10_Report_en.pdf

⁶ WHO. *Guidelines for the programmatic management of drug-resistant tuberculosis: Emergency Update 2008* (WHO/HTM/TB/2008.402). Geneva, Switzerland: WHO, 2008.

⁷ WHO. *Guidelines for the programmatic management of drug-resistant tuberculosis - 2011 update* (WHO/HTM/TB/2011.6). Geneva, Switzerland: WHO, 2011.

Recommended MDR-TB activities include the following:

1. Prevention
Address the factors leading to the emergence of MDR-TB:
 - Strengthen national drug regulatory authorities to ensure proper registration, availability, quality, safety and distribution of second-line drugs.
 - Strengthening basic TB control activities in both public and private sectors.
 - Develop and implement infection control measures in all levels of health facilities.
2. Case detection
 - Appropriate case-finding activities based on the local epidemiological situation and local capacity for diagnosis of M/XDR-TB cases.
 - Establish and/or strengthen appropriate laboratory services for the diagnosis of M/XDR-TB patients (including drug susceptibility testing for first- and second line TB drugs, and the introduction of newer and rapid diagnostic technologies).
 - Establish and/or strengthen appropriate systems for transport of sputum samples for diagnosis and follow-up of M/XDR-TB patients.
3. Care
 - Implement appropriate models of care for M/XDR-TB cases, including use of in-patient, ambulatory and community-based care as required.
 - Ensure consistent supply of quality-assured second-line TB drugs for the treatment of MDR-TB patients at all levels of the health system, with the establishment and/or strengthening of stocking and distribution systems.
 - Develop and/or strengthen support systems for M/XDR-TB patients and their families, as well as for staff and treatment providers.
 - Provide appropriate palliative care for those M/XDR-TB patients who have failed all available curative treatment.
4. Monitoring and evaluation
 - Conduct appropriate surveillance of M/XDR-TB prevalence among TB patients.
 - Implement and/or update comprehensive standardized recording and reporting systems (preferably electronic systems), which link laboratories, treatment sites, drug stores and program management units.
 - Establish and/or strengthen mechanisms for the monitoring and management of adverse drug effects.
5. Human resource capacity
 - Increase human resource capacity through the provision of appropriate standardized M/XDR-TB related trainings for staff at all levels of health systems, adequate pay, motivation of staff and professional recognition, and the provision of supportive supervision activities.
 - Establish M/XDR-TB management expertise within the national TB program structure to ensure efficient organization and coordination of services with local institutions, the general medical and social services, and other relevant partners.
6. National policy
 - Set up national-level expert M/XDR-TB committees or advisory bodies to guide policy development and provide oversight for the implementation of services.
 - Strengthening linkages with HIV programs to ensure appropriate services and care are provided to all HIV-positive M/XDR-TB patients.

Key resources

The key resources used in preparation of this information note in collaboration with technical partners are listed below. These resources provide details and discussions on the strength of the evidence on the internationally recommended M/XDR-TB interventions.

WHO. *Beijing “Call for Action” on tuberculosis control and patient care: together addressing the global M/XDR-TB epidemic*. Beijing, 2009.

http://www.who.int/tb_beijingmeeting/media/en_call_for_action.pdf

WHO. *Guidelines for the programmatic management of drug-resistant tuberculosis: Emergency Update 2008* (WHO/HTM/TB/2008.402). Geneva, Switzerland: WHO, 2008.

http://whqlibdoc.who.int/publications/2008/9789241547581_eng.pdf

WHO. *Guidelines for the programmatic management of drug-resistant tuberculosis - 2011 update* (WHO/HTM/TB/2011.6). Geneva, Switzerland: WHO, 2011.

http://whqlibdoc.who.int/publications/2011/9789241501583_eng.pdf

WHO. 62nd World Health Assembly. *Prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis*. WHA62.15. Eighth plenary meeting, 22 May 2009. A62/VR/8. http://apps.who.int/gb/ebwha/pdf_files/A62/A62_20-en.pdf

WHO. *Multidrug and extensively drug-resistant TB (M/XDR-TB): 2010 global report on surveillance and response*. WHO/HTM/TB/2010.3. Geneva, Switzerland: WHO, 2010.

<http://www.who.int/tb/publications/2010/en/index.html>.

WHO. *Policy recommendations on the use of liquid culture (2007), second-line drug susceptibility testing (2008), and the use of line probe assays for rapid MDR-TB screening (2008)*. Geneva, Switzerland: WHO, 2007 and 2008.

http://www.who.int/tb/laboratory/policy_statements/en/

WHO. *Guidance on ethics of tuberculosis prevention, care and control*.

WHO/HTM/TB/2010.16. Geneva, Switzerland: WHO, 2010.

<http://www.who.int/tb/publications/2010/en/index.html>.

WHO. *Guidelines for surveillance of drug resistance in tuberculosis*, 4th ed. Geneva, Switzerland: WHO, 2009.

http://whqlibdoc.who.int/publications/2009/9789241598675_eng.pdf.

WHO. *Antiretroviral therapy for HIV infection in adults and adolescents*.

Recommendations for a public health approach: 2010 revision. Geneva, Switzerland: WHO, 2010.

http://whqlibdoc.who.int/publications/2010/9789241599764_eng.pdf

WHO. *Policy on TB Infection Control in Health-care facilities, Congregate Settings and Households*. (WHO/HTM/TB/2009.419). Geneva, Switzerland: WHO, 2009

<http://www.who.int/tb/publications/2009/en/index.html>.