Multicountry Priority Area
Terms of Reference Open for Consultation

Tuberculosis: Improving quality of care and prevention of DR-TB in Eastern Europe and Central Asia

7 December 2017

Priority: Improving quality of care and prevention of DR-TB in Eastern Europe and Central Asia
Upper ceiling Allocation: US$ 5,000,000
Max. Number of grants: 1
Grant duration: 3 years
Multicountry approach: Based on the Global Fund Board's decision (GF/B36/04) in November 2016 on the Catalytic Investments available during the 2017-2019 Allocation Period, US$ 5,000,000 has been made available for Improving quality of care and prevention of DR-TB in Eastern Europe and Central Asia under the Multicountry approach. The amounts and priority areas for Catalytic Investments have been determined primarily by technical partners in consultation with the Global Fund Secretariat, and reflect critical needs that will assist in the delivery of the global plans for HIV, TB, and malaria and the 2017-2022 Global Fund Strategy. Under the recommendation of the Global Fund Board and technical partners, unless an ideal Applicant can be agreed through comprehensive regional consultations, the funds will be allocated through an open and competitive Request for Proposal (RFP) process.

All comments on the draft Terms of Reference should be sent to Rosalie Laurent Rosalie.Laurent@TheGlobalFund.org by January 7, 2018 midnight CEST time.

Epidemiological context

The tuberculosis (TB) incidence in the WHO European Region increased sharply from 1990 until reaching its peak in 1999, after which it fell slowly by an average of 5% per year during 2006–2016. According to WHO, the estimated incidence rate for all TB cases in Eastern Europe and Central Asia (EECA) was 32/100.000 in 2016. Deaths attributed to TB also fell dramatically over the past decade: from 7 per 100.000 population in 2006 to 2.8 per 100.000 in 2016.

In 2016, the reported TB notification rate was 28.5/100.000, of which 27% were previously treated cases. Males represented two-thirds of the TB notifications while children represented 4%.

While the ten years of decreasing trends of TB incidence and mortality rates represent major achievements of TB control in EECA, the evolution and increase of Drug Resistant TB (DR TB) and TB/HIV co-infection rates in EECA are alarming. The WHO European Region includes nine of the 30 countries worldwide with the highest MDR TB burden. In 2016, an estimated 19% of new cases and 55% of previously treated cases had RR/MDR TB – giving a total estimated number of new

RR/MDR-TB cases at 122,000. In the same year, only 49,442 RR/MDR TB cases were diagnosed (40%), a fraction of the total burden. Of those diagnosed, 47,846 RR/MDR TB cases began second-line treatment (97%), however, treatment success rates leave room for improvement, with only 54% of the last cohort for which full data is available[1] successfully completing treatment. XDR TB is rapidly emerging and as many as 22% of all RR/MDR TB cases tested for resistance to second line drugs were XDR TB (Global TB report 2017).

With a 60% increase in the number of new HIV infections between 2010 and 2016, EECA is the only region where the rate of new HIV infections continues to rise. TB/HIV co-infection is also deteriorating in the region: among 84% of new and relapse TB cases tested for HIV, 15% were found to be HIV positive. At the same time, only 66% of TB/HIV co-infected patients were enrolled on ARV treatment. Quality of care for TB/HIV patients remains a problem – only 62% of TB/HIV co-infected patients were successfully treated in comprising with 78% globally (2015 cohort).

Scope of the funding proposal

The funding proposal should cover countries in EECA region and ensure that it meets Global Fund eligibility requirements for multi-country proposals[2]. The rationale for country inclusion should be transparent and clearly described in the funding proposal. While the funding proposal is likely to focus on specific countries, the benefits of the proposed regional grant should include measurable regional health benefits beyond them.

In addition to the above, the proposal for the EECA multi-country tuberculosis grant is expected to meet the following criteria:

1. Align with the WHO's End TB Strategy and contribute to measurable impact and outcomes at the regional level by adding value to the existing Global Fund country grants and efforts supported by other stakeholders;
2. Build on a proven record of past success in producing impact on TB in multicounty settings and in reforming the models of TB care;
3. Support efficient knowledge sharing networks and communities of practice with particular emphasis on the TB doctors, primary care doctors, nurses, and other clinicians so as to bring specialty-level TB care to patients in their own communities;
4. Promote efficient service delivery platforms including integrated delivery systems addressing TB and co-infection with other diseases such as HIV, to maximize impact of investment;
5. Support at least two of the three strategic focus areas outlined below;
6. Demonstrate transparency and inclusiveness throughout the process of proposal development and grant implementation.

Strategic focus

Area 1: Improving the DR TB diagnostics

Diagnosing DR TB cases quickly and accurately is one of the main interventions to prevent the spread the DR TB. Only 49,442 cases out of the 122,000 estimated incident RR/MDR TB cases were diagnosed in the EECA region in 2016, which corresponds to 40% detection coverage[3]. A survey of the national TB policies and practices in 8 countries of EECA region found that 75% countries adopted policies to use Xpert MTB/RIF, as an initial testing technique, however only 63%

[1] WHO Global TB report 2017 – data for 2014 cohort;
[2] 51% of selected countries should be eligible for the Global Fund TB funding for 2017-2019 allocation period.
[3] WHO. Global TB report 2017, October 2017

have implemented the policy widely[4]. In 2016, only 50% of new, and 65% of previously treated cases, were tested for rifampicin resistance (including Xpert). Out of 49,442 RR/MDR TB cases, only 13,994 were tested for resistance to second-line TB drugs (28%), despite the almost universal inclusion of the recommendation in the courtiers' guidelines (MSF survey). In order to improve case detection and initiation on appropriate treatment regimens for RR/MDR TB and XDR TB, countries need to accelerate the use of rapid first- and second-line DST.

Indicators and expected outcomes:

- Increased number of RR/MDR TB cases detected and improved detection coverage;
- Universal access to rapid detection of RR/MDR TB among retreatment cases;
- Improved screening of RR TB among new TB cases and improved coverage;
- Increased utilization of rapid second-line DST among RR/MDR TB cases;
- New technologies and innovations aimed at detection of DR (including XDR) TB cases piloted;

Potential activities:

- Support the laboratory and diagnostic system in certification, accreditation, quality assurance and improving patient access;
- Development and scale-up of continuous quality improvement systems for the optimal utilisation of new technologies – such as GeneXpert and Hain Genotype MTBDR plus line Probe Assay;
- Revise and update policies and guidelines on TB and DR TB diagnostics according the most recent evidence and WHO recommendations;
- Support countries to implement the WHO recommended tools for rapid diagnosis of DR/XDR TB;
- Adapt and pilot new innovative tools and approaches;
- Work to increase the national resource allocation to diagnostic models.

Area 2: Improving the quality of DR TB treatment

The treatment success rate for RR/MDR TB patients in EECA is 54% for 2014 cohort. The high rate of treatment interruption is related to a number of factors, including the long duration of conventional treatment regimens for DR TB and the poor management of adverse drug reactions. Introduction and rapid scale up of shorter treatment regimens (STR) for DR TB cases could solve some of the barriers and improve treatment outcomes as well as reduce transmission of DR TB. However, only a few EECA countries have introduced STR and none of them have implemented it widely for the eligible patients (including paediatric cases).

The region is quite cautious in implementing new TB drugs - Bedaquiline, Delamanid and re-purposed second-line medications. While some countries have started to use them, the coverage remains very low and significantly lower than the WHO targets. In addition, only a few countries have included them in their Essential Medicines List (EML). Few have registered the new drugs with the local drug regulatory authorities. National pharmacovigilance systems are not sufficiently strong to support introduction of new TB medicines.

[4] MSF, Stop TB. Out Of Step in EECA: TB policies in 8 Countries in Eastern Europe and Central Asia; November 2017.

The national regulations and procurement practices often create barriers to accessing high quality affordable medicines.

Indicators and expected outcomes:

- Improved RR/MDR TB treatment success rate;
- Number of countries which implemented shorter treatment regimen;
- Number of DR TB patients enrolled on shorter treatment regimen;
- Reduced barriers for procurement of affordable TB medicines of assured quality;
- Number of countries which included Bedaquiline, Delamanid, Clofazimine and Linezolid into EML;
- Number of DR TB patients covered by aDSM approach (Active Drug safety monitoring and management).

Potential activities:

- Use innovative technology to develop in underserved areas, local RR/MDR TB case-management expertise that is equivalent to that delivered at the centres of excellence;
- Facilitate the scale-up of shorter regimes and new drugs, link the isolated clinicians into communities of practice and institute continuous quality improvement systems for the scale up of the shorter treatment and the new drugs;
- Support optimized procurement through the national and international mechanisms allowing best value for money and quality assured medications;
- Support National Drug Regulatory Authorities in their effort to simplify registration procedures for new TB medicines;
- Strengthen the Pharmacovigilance systems in the collection and analysis of information on adverse effects for TB medicines and link it to the clinical management to identify the patients who are not adhering to medication.

Area 3: People-Centered approach

Deficiencies of the health systems contribute to the alarming rates of M/XDR TB in EECA. Significant challenges persist in adapting the care delivery to enable the provision of people-centered services, especially among vulnerable groups. The continuing focus on hospital-based care and the vertically organized TB services are lacking sufficient integration, with the primary health care (PHC), and with other services for infectious diseases, including HIV. Many of the current models of TB care in the EECA region do not sufficiently draw on some of the more innovative models for patient-centred care, including a greater emphasis on ambulatory-based treatment and engagement of local communities and civil society to support treatment adherence. In addition, HIV co-infection, alcohol and substance abuse are strong determinants of poorer treatment outcomes. As a result, treatment success rate for DR TB cases remains unacceptably low and cost of delivering DR TB care remains excessively high.

Indicators and expected outcomes:

- Improved treatment success rate for TB and RR/MDR TB cases;
- Decreased proportion of RR/MDR TB among retreatment TB cases;
- Decreased RR/MDR TB incidence rate;
- Decrease the hospitalization rate for TB and DR TB cases;

- Shortened hospital stay for TB and DR TB patients;
- Improved allocative efficiency for the National TB programs.
- Potential activities:
- Significantly increase provider capacity and standardize consistent quality across geographies of the countries and across countries;
- Promoting platforms for inclusive and integrated team-based, inter-professional patient-centred models of care with tailoring the services for vulnerable populations;
- Accelerating health sector and TB reforms, increasing ambulatory treatment and civil society and communities' engagement.