

# Evaluation of the Global TB Drug Facility

STOP TB PARTNERSHIP  
C/O WORLD HEALTH ORGANIZATION

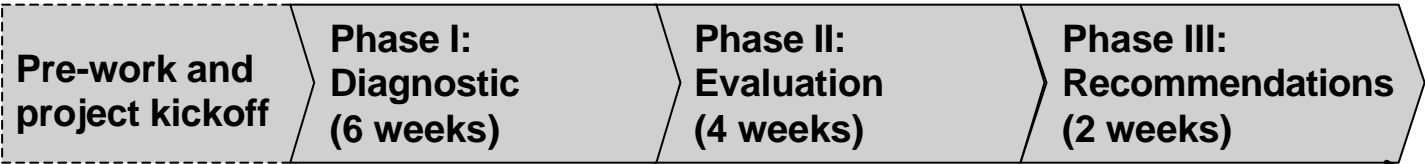
Supporting Exhibits

April 2003

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# OVER 180 INTERNATIONAL, REGIONAL AND LOCAL EXPERTS AND STAKEHOLDERS HAVE BEEN CONSULTED AND 10 COUNTRIES VISITED

**Approach for GDF evaluation**



## Interviewees – International/regional experts and stakeholders

## Country visits

Lina Abrahan	Chris Dye	Fabio Luelmo	Holger Sawert
Paul Acriavadis	David Ernst	Dermot Maher	Fabios Scano
Dongil Ahn	Marcus Espinal	Dee Jay Mailer	Bernard Schwartlander
Nadia Aitkhaled	Peter Evans	Robert Matiru	Peter Small
David Alnwick	Richard Feacham	Michael McCullough	Ian Smith
BRL Ploos van Amstel	Paula Fujiwara	Ariel Pablos-Mendez	Lisa-Marie Smith
Virginia Arnold	Malgosia Grzemska	Lucy Moore	Anthony So
Susan Bacheller	Jack Gottling	Tom Moore	Marni Sommer
Guido Bakker	Penny Grewal	Toru Mori	Anil Soni
Emma Beck	Johan van der Gronden	Poul Muller	Bo Stenson
Francoise Benoit	Brigitte Heiden	Vasant Narsimhan	Lynn Taliento
Yves Bergevin	Renee Herminez	Eva Nathanson	Yolanda Tayler
Henk den Besten	David Heymann	Paula Nersisian	Kate Taylor
Nils Billo	Ernesto Jaramillo	Paul Nunn	Arnaud Tebaucq
Leo Blanc	Daniel Kibuqa	Bernard Pecoul	Michael Thuo
Franceska Boltrini	Jim Yong Kim	Joseph Perriens	Tom Topping
Andrea Bosman	Dr. Kochi	Antonio Pio	Jan Voskens
Jaap F. Broekmans	Jacob Kumaresan	Jonothan Quick	Hugo Vrakking
Richard Bumgarner	Irene Kuok	Jim Rankin	Catherine Watt
Emanuele Capobinco	Richard Laing	Eva Rard	Diana Weil
Andrew Cassels	Ken Langford	Mario Raviglione	Roy Widdus
Umberto Cancellieri	Tom Layloff	Alistair Reid	Hilary Wild
Brendan Daly	Peter Potter-Lesage	Irene Rizzo	Andre Zagoriskiy
Susanne Detreville	Christopher Lovelace	Rodrigo Romulo	Richard Zaleskis
Lucica Ditiu	Ernest Loevinsohn		

- GDF grantees*
- India
  - Kenya
  - Moldova
  - Myanmar
  - Nigeria
  - Philippines
  - Somalia
  - Uganda
- Non-GDF grantees*
- Romania
  - South Africa

# GDF HAS A TWO-PART MISSION: TO EXPAND ACCESS TO HIGH QUALITY TB DRUGS AND TO INDIRECTLY FACILITATE DOTS EXPANSION

Expected impact of GDF

- Direct
- Indirect

**DOTS success factors**

**Description / examples**

<b>Drug supply</b>	<ul style="list-style-type: none"> <li>• A regular, uninterrupted supply of all essential anti-TB drugs</li> </ul>
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<b>Government commitment</b>	<ul style="list-style-type: none"> <li>• Government commitment to TB control through DOTS, as evidenced by level of priority given to TB control, establishment of dedicated TB budget, appointment of senior staff, etc.</li> </ul>
<b>Infrastructure</b>	<ul style="list-style-type: none"> <li>• E.g. well-functioning in-country drug distribution, warehouses, clinics, lab equipment</li> </ul>
<b>Funding</b>	<ul style="list-style-type: none"> <li>• Funding for ongoing TB control operations (e.g. salaries, supplies) and for expansion (e.g. training)</li> </ul>
<b>Technical assistance</b>	<ul style="list-style-type: none"> <li>• Building medical / nursing / management capacity</li> </ul>

**"The Global Drug Facility (GDF) will expand access to, and availability of, high quality TB drugs and will thereby facilitate DOTS expansion"**

# GDF IS A LEAN PARTNERSHIP WITH COLLABORATING AND CONTRACTUAL PARTNERS AND A SMALL DEDICATED SECRETARIAT

## Grant making – collaborating partners from the Stop TB Partnership

- Donors: CIDA, Government of Netherlands, USAID, World Bank



## Procurement – Contractual partners\*

- Procurement services - UNDP/IAPSO
- Manufacturing - MEG/Svizera
- Quality control/PSI - SGS
- Freight forwarding - Kuhne & Nagle and Mahe
- Quality assurance - SGS & WHO

## Technical assistance – collaborating partners from the Stop TB Partnership

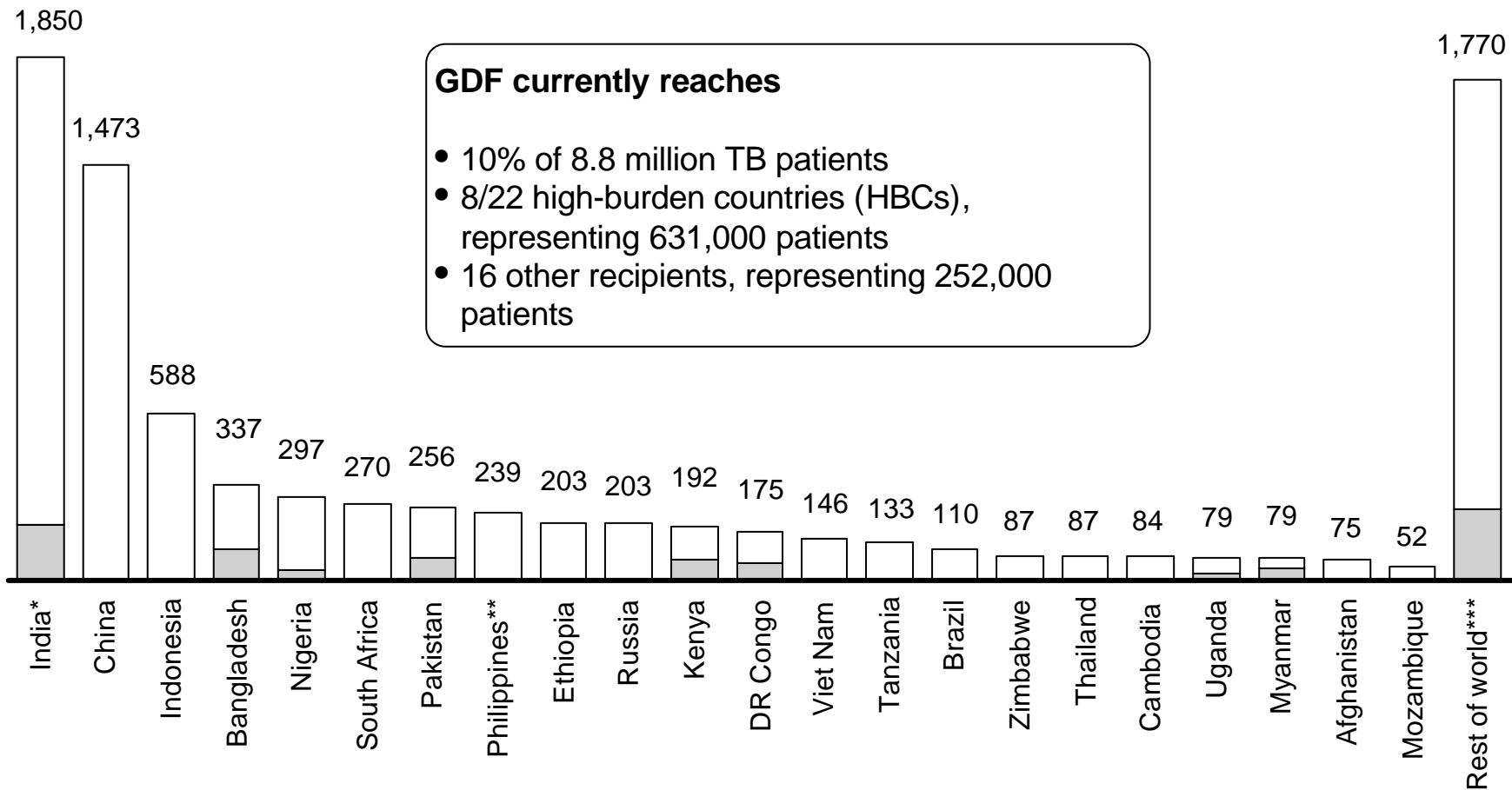
- WHO: Units like EDM, STB Department and regional/local offices
- Technical partners: E.g., GLRA, IUATLD, KNCV, MSH, NIPER, MRC, RIT Japan, World Bank, WHO

\* Could be potentially revised after current round of bidding

# Exhibit 4 GDF HAS DEVELOPED A BROAD REACH ACROSS COUNTRIES IN LESS THAN TWO YEARS OF OPERATION

Thousands of patients, 2002 (2001 HBC list)

Est. TB incidence (all types)  
 Patients treated with GDF drugs



\* India received a grant to buy drug from local suppliers

\*\* Direct procurement

\*\*\* 16 recipients: Djibouti, DPR Korea, Liberia, Moldova, Somalia, Sudan, Tajikistan, Togo, Armenia, Central African Republic, Congo, Gambia, Mauritania, Uzbekistan, Zambia, Orissa State (India)

# GDF HAS HAD A POSITIVE EFFECT ON BOTH DIRECT AND INDIRECT GOALS ACROSS THE 8 COUNTRIES STUDIED



**Direct goal:**  
Expanding access to high quality TB drugs



**Nigeria Myanmar Moldova Uganda Kenya Philippines India Somalia**

Alleviating drug shortage due to lack of funds

✓	✓	✓	✓	✓	✓	✓	✓	✓
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Alleviating drug shortage due to procurement issues

			✓		✓		✓	
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**Indirect goal:**  
Facilitating DOTS expansion

Improving drug management through standardization and innovation

✓	✓		✓	✓	✓			
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Releasing resources for other aspects of TB management

	✓		✓					✓
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Mobilizing political and partner commitment

✓	✓	✓		✓	✓			
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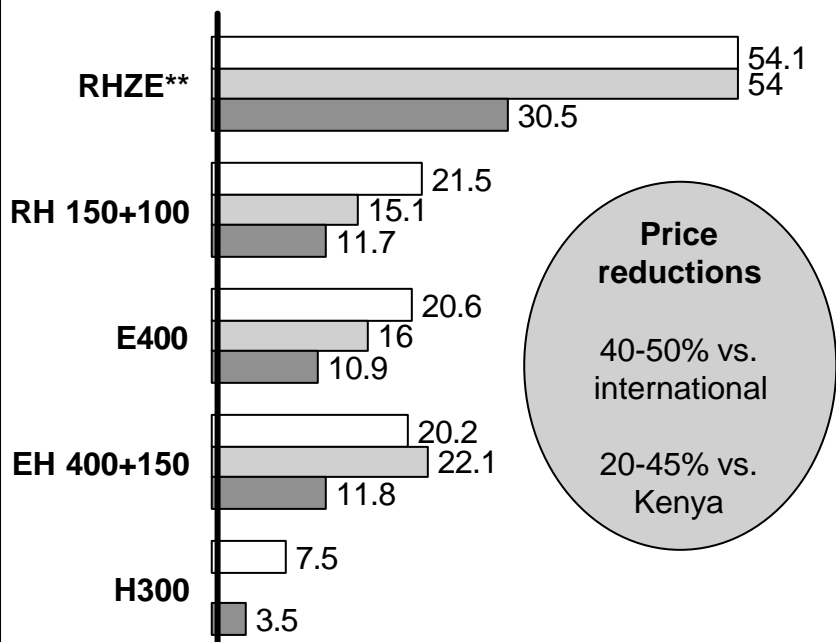
Source: Country visits; team analysis

# Exhibit 6

## GDF HAS ALSO IMPROVED THE PRICE AND QUALITY OF TB DRUGS, WHICH WILL BENEFIT ALL BUYERS

### GDF prices vs. international and Kenya government purchases\*

\$ per 1,000 tablets



### GDF impact on other aspects of TB treatment

- Standardization and innovation:** Promoted the use of logistically superior, patient-friendly treatment regimens like 4FDC, blister packs, and patient packs. E.g., With GDF encouragement, Myanmar and the Philippines are adopting 4FDC, paving the way for easier drug management, lower risk of monotherapy/drug resistance and drug leakages
- “White list” of suppliers:** Used its relationship with WHO to promote the development of a white list of pre-approved TB drug suppliers. This list can now be used by all buyers without routing purchases through GDF
- Awareness of quality and prices:** Raised awareness of shortcomings of local manufacturers. *“...after GDF brought up price and quality issues of TB drugs, the government of Indonesia is now asking local manufacturers for bio-availability data and justification of ~\$30 per patient treatment price...”*
- Facilitated access for underprivileged communities:** Grant conditions of free drugs and focus on countries with GNP < \$3000 per capita

\* Government of Kenya procurement before GDF

\*\* RHZE 150+75+400+275

# GDF HAS DELIVERS BENEFITS IN A COST-EFFECTIVE MANNER

Million USD, 2001-2002 Cumulative

*ON A FULLY-COSTED  
BASIS, INCLUDING  
DONATIONS,  
SECONDMENTS, ETC.*

	<u>Amount</u>	<u>% of total</u>
<b>Inflows (donations, grants-in-kind)*</b>	<b>21.0</b>	
<b>Cost of Goods Sold (procurement costs)</b>	<b>17.4</b>	<b>82.9%</b>
Drug cost, procurement service fee, freight, insurance	17.4	82.9%
<b>General and administrative expenses</b>	<b>3.6</b>	<b>17.1%</b>
Advocacy and communications	0.1	0.6%
Technical assistance and monitoring	0.5	2.4%
Quality assurance	0.5	2.4%
General and administrative	1.1	5.2%
GDF fixed term	0.2	
GDF short term	0.5	
STB Secretariat**	0.2	
Seconded staff***	0.2	
Indirect cost to WHO	1.4	6.4%

**GDF has spent 11.7  
USD per patient  
treated (given 1.8  
million cumulative  
patients treated over  
2001-02)**

\* Amount of carry over (\$2.2M) to 2003 is excluded in total inflows

\*\* ½ FTE Financial, contracting, HR; 1/5 FTE resource mobilization; 1/5 FTE Information management;  
1/10 FTE advocacy/communication

\*\*\* MSH/T. Moore, H. Vrakking; RIT/Y. Uchiyama

Source: STB Secretariat; Team analysis

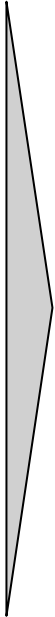
# GDF IS UNLIKELY TO NEGATIVELY AFFECT LOCAL PROCUREMENT ABILITY. HOWEVER, IT SHOULD INCREASE EMPHASIS ON PLANNING FOR PHASE-OUT

Skills required in procurement	Potential GDF impact	Recommendations
<ul style="list-style-type: none"> <li>Demand forecasting</li> </ul>	Positive <ul style="list-style-type: none"> <li>Application supports forecasting</li> <li>GDF can mobilize partners to help with demand forecasting</li> </ul>	<ul style="list-style-type: none"> <li>Continue to mobilize partners to help if this is a bottleneck</li> </ul>
<ul style="list-style-type: none"> <li>Budget allocation</li> </ul>	Positive <ul style="list-style-type: none"> <li>Application encourages TB drug budget line</li> </ul>	<ul style="list-style-type: none"> <li>Continue to encourage / enforce</li> </ul>
<ul style="list-style-type: none"> <li>Procurement agent selection, e.g. own procurement dept. versus agency selected via ICB</li> <li>Supplier evaluation / selection</li> <li>Price negotiation</li> </ul>	Neutral to potentially negative <ul style="list-style-type: none"> <li>In countries with poor overall procurement, reliance on GDF procurement for TB drugs could inhibit development of in-country procurement ability, making the country dependent on GDF or international aid agencies</li> <li>GDF serves a small part of the universe of procured TB drugs</li> </ul>	<ul style="list-style-type: none"> <li><b>Develop three-step phase-out</b> <ul style="list-style-type: none"> <li>Phase out grant</li> <li>Help build procurement ability</li> <li>Monitoring / oversight x 2 years</li> </ul> </li> <li><b>Help domestic suppliers qualify for 'white-list' status</b> <ul style="list-style-type: none"> <li>Mobilize technical assistance</li> <li>Offer flexibility on pricing during bidding process*</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>Quality assessment</li> <li>Drug registration and clearance</li> </ul>	Neutral to positive <ul style="list-style-type: none"> <li>GDF asks for efficient application of in-country QA, registration, and clearance rules, not waiver</li> </ul>	<ul style="list-style-type: none"> <li>--</li> </ul>
<ul style="list-style-type: none"> <li>In-country drug distribution</li> </ul>	Positive <ul style="list-style-type: none"> <li>Application helps identify distribution bottlenecks</li> <li>GDF can mobilize partners to help with in-country drug distribution</li> </ul>	<ul style="list-style-type: none"> <li>Continue to mobilize partners to help if this is a bottleneck</li> </ul>

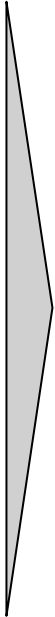
\* For example, 'emerging' suppliers could be allowed to win tender even if bidding x% higher than established suppliers

## Exhibit 9

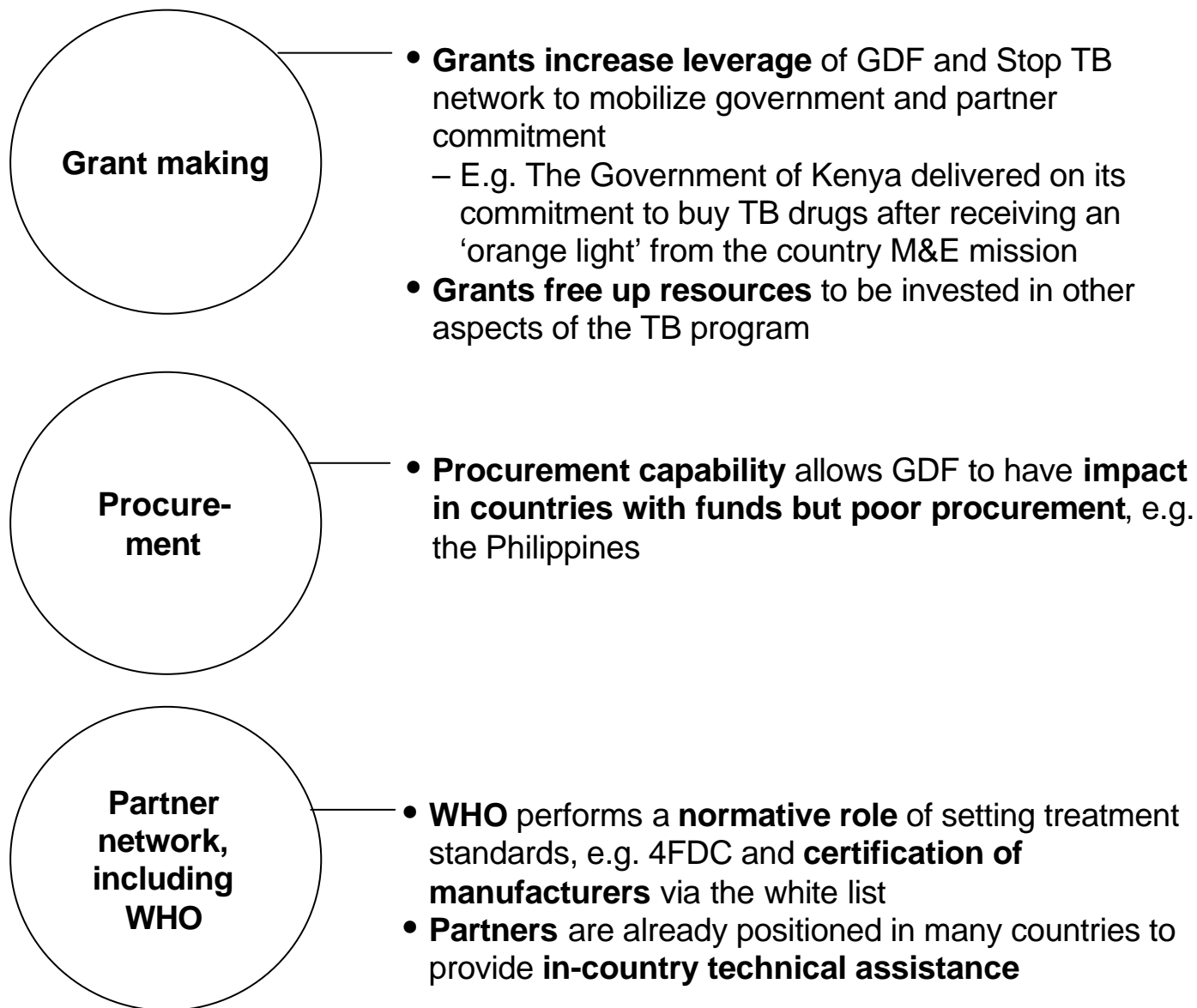
# GDF's IMPACT ON REGIONAL PROCUREMENT EFFORTS HAS BEEN NEUTRAL AND SHOULD CONTINUE TO BE SO

- Current information from countries served by GDF is that no major regional procurement effort was shelved or undermined as a result of GDF's activities
  - GDF's service lines are compatible with regional procurement
    - Regional procurement agents can use GDF direct procurement for qualifying member states. GDF could reach out proactively to these regions to gauge level of interest in region-level purchasing of GDF drugs
    - Countries with own funds have the option to choose GDF procurement / regional procurement / both
    - GDF's grant-in-kind function targets countries in which lack of funds is a bottleneck to drug availability. Grant-making for drugs is not a service offered by regional mechanisms currently
  - GDF's mission does not call for it to become a TB drug monopsony. GDF does not aim to grant more than 30% of the world market—indeed there are a number of HBCs that it will likely not serve at all. GDF's control of the supplier base will therefore not be enough to inhibit the development of regional procurement networks, if others are willing to develop them
- 
- To date, GDF has had no observable impact on the development of any potential regional procurement networks
  - GDF's mission is compatible with the existence of regional procurement networks
  - GDF's could assess regional agents' interest in purchasing of GDF drugs using the regional procurement mechanism

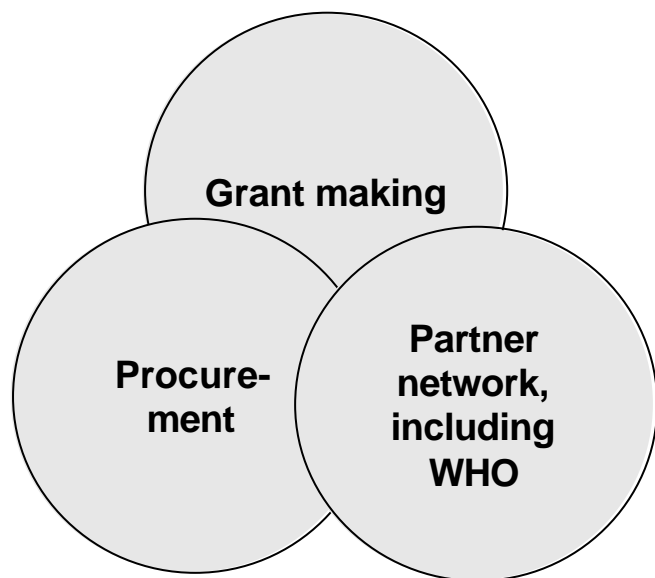
## GDF's EFFECT TO DATE ON LOCAL SUPPLIERS HAS BEEN NEUTRAL TO POSITIVE

- **Countries with their own TB drug supply have chosen not to use GDF, even if GDF procurement was cheaper.** E.g. South Africa (where local prices are three times GDF prices) and Romania. GDF impact on these countries' suppliers is therefore nil
  - **Many countries served by GDF do not have local TB suppliers, and procured internationally even before GDF's arrival.** E.g. in Nigeria, TB drugs are purchased by technical partners from a number of international suppliers. GDF impact on local suppliers in these countries is therefore nil
  - **GDF has stimulated the development of a WHO 'white list' of high-quality suppliers of TB drugs.** Local suppliers who qualify can therefore more easily have access to international markets. Some countries like the Philippines and Romania, have asked about how to encourage their local producers to qualify for the WHO white list. GDF impact in this case is positive
  - **GDF has stimulated governments of some countries with local manufacturers to evaluate more closely drug quality and price.** E.g. in Indonesia and Romania. GDF impact in this case is positive
- 
- Information from countries suggests that GDF's impact to date on local TB drug suppliers has been neutral to positive
  - With the expansion of the WHO white list, GDF will likely be able to be more flexible in meeting country requests for supply of quality drugs from local sources
  - Further, GDF could also indirectly help increase price and quality awareness, for example, through its advocacy and influencing the institution of a drug pricing commission in countries where drug prices are many multiples of GDF prices

# THE GDF MODEL HAS THREE ELEMENTS, EACH WITH ITS OWN BENEFITS



# IT IS THE BUNDLING OF THESE THREE ELEMENTS IN GDF'S PROPOSITION THAT GIVES IT GREATER IMPACT



- **Grants-in-kind of GDF-procured drugs** is more powerful to **mobilize partners** than grants alone
  - Free drugs are “real” products to kick start a program and hence, significantly energize governments and partners
  - Country examples: Moldova, Myanmar, Nigeria
  - *“...Why would anyone build capacity for diagnosis and treatment when there are no drugs to give people at the end of the process?...”*
  - Precedent in leprosy: *“...In leprosy, we changed the world when we were able to give free drugs in '95, everything else happened around that...”*
- **Grants and the partner network** allow GDF partners to provide relevant technical assistance to support the drug grant, not piece-meal or stand-alone support
- **Grants, the WHO link and procurement** allow GDF to **guarantee sufficient demand** to encourage manufacturers to produce the drugs and formulations recommended by WHO, reduce prices and promote standardization/innovations
- **Grants-in-kind linked to procurement** reach countries faster than through separate granting and procurement processes, and with fewer ‘leakages’
  - *“...even if GDF had given them money, it would have been a headache and impact would not have happened so fast. Drugs in kind is great”*

Exhibit 13


# GDF SHOULD FOCUS ON “NATURAL” AND “CHALLENGING” BENEFICIARIES WHO WILL MOST BENEFIT FROM THIS MODEL

Beneficiary segment	Examples	GDF approach
<ul style="list-style-type: none"> <li>• <b>“Natural beneficiaries”</b></li> <li>– No reliable supply due to funding or procurement gaps</li> <li>– Government willing and able to take action</li> <li>– GDF partners present</li> </ul>	<ul style="list-style-type: none"> <li>• Most countries, e.g. Moldova, Nigeria</li> </ul>	<ul style="list-style-type: none"> <li>• Approach proactively to offer assistance, e.g., initiate dialogue through WHO and other partners, contact through multiple channels in pre-application stage</li> </ul>
<ul style="list-style-type: none"> <li>• <b>“Challenging beneficiaries”</b></li> <li>– No reliable supply</li> <li>– No willing or able government <i>or</i></li> <li>– Few or no GDF partners in country</li> </ul>	<ul style="list-style-type: none"> <li>• Somalia, Myanmar</li> </ul>	<ul style="list-style-type: none"> <li>• Recognize that impact will be harder to achieve, but need is even greater</li> <li>• Expend more efforts to identify in-country technical partners, non-traditional agents and coordinating mechanisms</li> </ul>
<ul style="list-style-type: none"> <li>• <b>“Opportunistic beneficiaries”</b></li> <li>– Countries which usually have funds and ability to procure own drugs, but may benefit from GDF support (e.g. on a periodic or regional basis)</li> </ul>	<ul style="list-style-type: none"> <li>• India, South Africa, Romania</li> </ul>	<ul style="list-style-type: none"> <li>• Unlikely to serve with classic approach</li> <li>• Maintain dialogue, e.g. through Stop TB Partnership, to identify emerging opportunities to serve these countries</li> <li>• E.g., emergency needs; the institution of a drug pricing commission in South Africa, where drug prices are 3-4 times higher than GDF prices, may increase sensitivity to GDF’s value proposition</li> </ul>

**“Core” GDF beneficiaries**

# GDF HAS MET MUCH OF THE NON-DRUG RELATED NEED FOR ASSISTANCE BY MOBILIZING ITS PARTNER NETWORK OR THE GOVERNMENT

*ILLUSTRATIVE*

Constraint	Example from country visits		Most important constraints in HBC
Human resources	<ul style="list-style-type: none"> <li>• CIDA funded TB personnel training in Nigeria after GDF grant</li> </ul>		
Decentralization	<ul style="list-style-type: none"> <li>• NGOs procuring drugs in Nigeria are coordinating procurement through GDF</li> </ul>		
Private sector	<ul style="list-style-type: none"> <li>• PHILCAT and NTP in Philippines are co-championing the PPM pilot applying DOTS principles with a GDF grant</li> </ul>		
Infrastructure	<ul style="list-style-type: none"> <li>• Nigerian government (federal and state) committing to infrastructure upgrades</li> <li>• JSI-DELIVER project with Kenya's NTP for in-country drug management</li> </ul>		
Political commitment	<ul style="list-style-type: none"> <li>• Moldovan government committing to DOTS expansion plan</li> </ul>		
Access to DOTS	<ul style="list-style-type: none"> <li>• DOTS expansion to 16 regions in Nigeria once GDF drugs arrive there</li> </ul>		
Financing	<ul style="list-style-type: none"> <li>• Other donors stepping in to Moldova after GDF grant</li> </ul>		
Community awareness	<ul style="list-style-type: none"> <li>• Myanmar MOH beginning social mobilization plans with JSI</li> </ul>		
Monitoring	<ul style="list-style-type: none"> <li>• ...</li> </ul>		
Drugs	<ul style="list-style-type: none"> <li>• ...</li> </ul>		
Laboratories	<ul style="list-style-type: none"> <li>• ...</li> </ul>		
HIV/AIDS	<ul style="list-style-type: none"> <li>• ...</li> </ul>		

# GDF DOES NOT NEED TO ALTER/EXPAND ITS PROPOSITION. IT CAN MEET DRUG-RELATED GAPS THROUGH BETTER PARTNER MOBILIZATION

## From a customer need perspective...

- GDF has been able to influence most barriers by mobilizing its partner network. Better execution on this dimension will further improve GDF's impact
- Few non-drug barriers are common across countries. Any one new activity would help only a small subset of countries

## From the GDF's operational perspective...

- Any new service line would require GDF to obtain significant funding, expertise, or both, e.g.
  - Changing the Ugandan procurement system from 'push' to 'pull' required DELIVER to "...get DANIDA funding and do one year of consulting work... and that was in a favorable environment where the government wanted change and DANIDA was pushing for it..."
- Such new areas would likely overlap with activities of STB technical partners, leading to duplication
- New activities, especially those not directly related to drug supply and fragmented across small groups of countries, could detract focus from GDF's core operations

## Recommendations

- GDF should not directly provide such assistance to countries
- However, GDF should:
  - Explicitly assess these barriers during application and M&E
  - Mobilize partners to provide assistance where needed
  - Where no partners available, develop one-off solutions
- At a systemic level, GDF should continue to facilitate low-investment, high-impact actions. These could be, for example,
  - **Facilitate subject-specific conferences** (e.g., Washington Conference on Drug Management)
  - **Share best practices across countries** (e.g., transition to FDC, use of drug grants in public-private programs)
  - **Facilitate the publication of guidelines through WHO** (e.g., 4FDC guidelines/training manual)

# EFFECTIVENESS OF GDF'S FULL VALUE PROPOSITION DEPENDS ON IT PROVIDING GRANTS

*GDF can help address some drug shortage issues via direct procurement alone...*

*...but having an impact on non-drug bottlenecks is dependent on the 'carrot' of providing grants and the 'stick' of post-grant M&E*

## GDF intervention

### Direct procurement

- Allows countries to buy quality drugs more cheaply through GDF, and thereby reduce procurement-related problems in drug supply for DOTS

### Grants

- Encourage governments to develop strong DOTS plans to win grant and attract other donors
- With associated M&E, encourage governments to honor commitments and ensure rational use to be eligible for more aid
- Allow funds to be reallocated to meet resource gaps in non-drug areas and be invested in technical assistance
- Allow GDF to mobilize and coordinate actions of partners

## Potential bottlenecks in DOTS expansion

**Drug supply due to procurement issues**

**Drug supply due to funding gaps**

**Political commitment and planning**

**Other bottlenecks, For example,**

- Human resources
- Infrastructure
- Laboratories

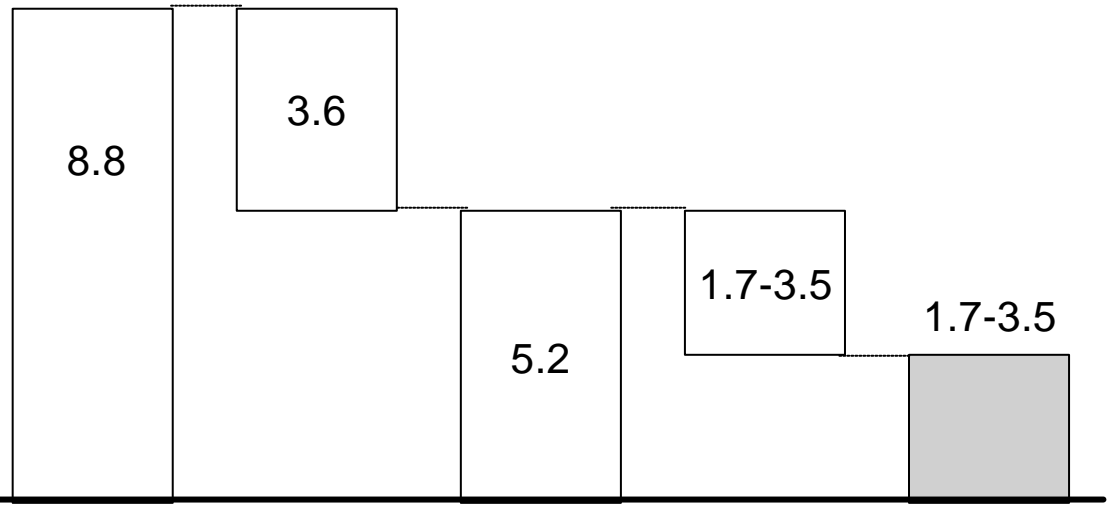
# IN THE ABSENCE OF GRANTS, GDF'S IMPACT DIMINISHES ACROSS ALL POSSIBLE SCENARIOS

Scenario	Description	Implications for the GDF
<b>Direct procurement agent</b>	<ul style="list-style-type: none"> <li>• Donor gives grant to country, and maintains M&amp;E function</li> <li>• Country has choice of procurement agent, including the GDF</li> </ul>	<ul style="list-style-type: none"> <li>• The GDF would lose               <ul style="list-style-type: none"> <li>– Financial leverage (both carrot and stick) to encourage DOTS expansion</li> <li>– Ability to promote standardization of TB treatments</li> <li>– Access to a range of countries with non-level playing fields</li> </ul> </li> </ul>
<b>Recommended procurement agent</b>	<ul style="list-style-type: none"> <li>• Donor gives grant to country and maintains M&amp;E function</li> <li>• Donor recommends the GDF as procurement agent</li> </ul>	<ul style="list-style-type: none"> <li>• The GDF would lose financial leverage to encourage DOTS expansion</li> </ul>
<b>Mandated procurement agent</b>	<ul style="list-style-type: none"> <li>• Donor gives grant to country and mandates the GDF as procurement agent</li> <li>• Donors delegates M&amp;E function to the GDF</li> </ul>	<ul style="list-style-type: none"> <li>• No diminished impact for the GDF, but only if donor agrees to GDF-driven application, review and M&amp;E process and decision-making, so that the GDF retains the carrot and the stick</li> <li>• Would any donor give up this degree of control over M&amp;E?</li> </ul>

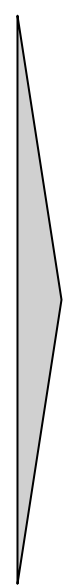
# GDF's DIRECT GRANT-MAKING ROLE CAN BE SUSTAINED WITH FUNDING LEVELS OF ~\$20-40 MILLION PER YEAR

TOP-DOWN ESTIMATE

Million cases p.a., 2002



Estimated TB incidence	Less: Cases in "opportunistic" beneficiaries	Cases in "natural" and "challenging" beneficiaries	Less: 1/3-2/3 demand that GDF will not meet	1/3-2/3 demand that GDF will meet through grants
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- It is neither necessary nor desirable for GDF to grant 100% of a country's needs
  - Discourages countries' from having budget lines
  - Makes exit harder
  - Reduces competition and local procurement capacity
- At \$10-12 per treatment course, GDF will require ~\$20-40M per year for drug grants

GDF will prioritize grant recipients based on ability to have impact on their DOTS program, in addition to drug need. Hence, focus on "natural" and "challenging" beneficiaries

Grants of 1/3-2/3rd of country needs is adequate for GDF to catalyze DOTS expansion

- 30% budget gap in HBCs
- Meaningful level for leverage
- Countries can use direct procurement for the rest

# GDF'S BUSINESS MODEL HAS SERVED IT WELL IN MEETING THE NEEDS OF AN ORGANIZATION IN A "START UP" MODE

## Grant-making

- Sustained donor commitment for years 1 and 2; >80% of funds disbursed
- However, significant shortfall for 2003, and no commitments yet for 2004+
- Limited cash flow planning and unclear communication to the Board
- Limited advocacy and brand-building to broaden funding base

## Application/ review

- Awareness building at system/country level largely through emails during application or WHO/STB partners; limited budget for advocacy
- TRC a well-functioning team, highly regarded for its experience, technical expertise and independence
- Processes for application/review set up very quickly, but team overstretched and lead times longer than targeted; M&E systems nascent

## Procurement

- First approach for selection of procurement agent/supplier in 2001 designed for rapid launch; however, not fully in line with donor/partner expectations
- Negotiated price reductions significantly below international norms
- Good initiatives on standardization/innovation in products. Can improve through user-friendly disease information and introducing drugs for treatment of children

## Coordination of Stop TB partners

- STB partners present and mobilized to some extent in most countries. However, where traditional partners not present (e.g. Somalia), relationships with other partners not proactively established
- Partners positive and helpful in cases where applications come from the NTP. Limited track record where applications come from NGOs/non-traditional partners
- More proactive partner mobilization around identified gaps needed to ensure impact beyond access to drugs alone

# GDF MUST IMPROVE OPERATIONS IN THREE KEY AREAS

## Recommendations

### Build awareness/ advocacy for GDF

- Engage in significant “brand-building” both with country beneficiaries and donors/STB partners in order to raise more funding, catalyze partners for DOTS expansion and increase leverage with governments. For example,
  - Budget for advocacy and brand building
  - Publicity strongly linking DOTS and GDF
  - Contacts between high-level GDF/STB members and government officials
  - Contacts with in-country NGOs, technical advisors
  - Building awareness with key donors, foundations, partnerships and partners

### Mobilize partners

- Fully leverage WHO across all countries for advocacy, communication with MoH/NTP, relationships with partners, TA and facilitate drug entry into port
- More proactively involve partners, especially non-traditional parties
  - Strengthen applications with partner input
  - Encourage ‘ownership’ of key country bottlenecks
  - Map list of in-country stakeholders during application process and engage with non-core partners
  - Ensure M&E visits involve all key in-country partners

### Strengthen procurement

- Redesign tender process - LICB, with multiple suppliers for each product (being done currently)
- Publicize new process to undo negative perception
- Review appropriateness of application review and monitoring requirements for direct procurement, as well as economics for GDF, procurement agent and country
- Clearly communicate processes/economics of direct procurement to key stakeholders

# GDF'S MANAGEMENT TEAM HAS LARGELY MET EXPECTATIONS

- Needs fully met
- ◐ Somewhat met
- Not met

Needs in start-up mode

**Lean and innovative management team**



**Assessment**

**Quotes/examples**

- Made GDF operational in a short time with a very lean staff
- Used secondments for technical expertise (e.g. procurement, drug management)
- High level of commitment, “can do attitude” and willingness to experiment; *“Highest marks for hard work, conscientious, enthusiasm, responsiveness”*
- Demonstrated ability to grow into stretch role and if coached, have potential to develop further
- However, short-staffed for future growth, with some gaps in skills and formal systems, e.g., brand-building, financial planning and M&E

**Dynamic and technically strong leadership**



- To many partners, Ian Smith represents the GDF – *“Ian has demonstrated excellent management and leadership skills.”*; *“He has found a way to apply private sector approaches in a public sector setting despite huge opposition”*
- However, critical vacuum in leadership with current transition

**Credibility and access to countries**



- Accessed countries through WHO offices and partner links in countries. WHO linkage also provides credibility to solicit applications
- However, regional and country WHO staff often unclear on their full role with respect to the GDF and sometimes, over-stretched to meet this additional commitment

**Access to technical expertise**



- TRC highly regarded as a technically competent, independent and well-balanced team with depth of functional and regional expertise – *“One of the most impressive and capable group of people –they take their job seriously”*
- TRC processes continuously being improved to reduce lead times, facilitate more informed discussions, reduce travel for members, etc.

**Smooth coordination with Stop TB partners and other efforts**



- GDF management team seen as being responsive to partners' suggestions and accountable to the STBCB
- After initial issues in working with WHO departments, GDF and WHO now actively cooperate, e.g. with the DOTS expansion Working Group and EDM
- However, communication with partners and mobilization for TA must be improved

# HOWEVER, GOING FORWARD, THE TEAM WILL NEED TO BE STRENGTHENED TO FULLY MEET THE NEEDS OF A GROWING GDF

## Key challenges

## Issues

### Critical leadership transition

- Significant transition with exit of three key people (Ian Smith, Jacob Kumaresan, J.W.Lee) perceived as providing technical credibility, maturity in dealing with partners and ensuring a balanced role for WHO
- Critical to find a new leader with a balance of skills – managerial expertise to complement technical skills; political maturity to handle multiple partners; suitably strong profile to be the face of GDF and support its brand-building and fund-raising efforts

### Staff shortage and skill gaps; Few robust professional systems

- Significant staff shortage to support GDF growth. Current team running at significantly >100% utilization, resulting in de-prioritization of key efforts like M&E, advocacy and strategic planning
- Staff perceived to be high on enthusiasm but low on experience. This is exacerbated by short term contracts and contract breaks, causing gaps in institutional memory. Some have also suggested that GDF tap a broader range of expertise through secondments or consulting contracts, beyond WHO
- Some skill and system gaps in important functions, namely advocacy/brand building; strategic, financial and operational planning; M&E and knowledge management
- Informal style of communication has worked within the team; however, communication with partners, the Stop TB Partnership and Board, in-country agents and WHO have not always been adequate or efficient

### Evolving organizational structure

- GDF's reporting structure works on two dimensions - country servicing and functional expertise, both of which are expanding in parallel. Developing an appropriate flexible matrix reporting structure to deliver against this would be critical
- Emerging matrix structure matches current functions, but important issues need to be addressed:
  - Shared responsibility for country between supply and demand side requires close coordination between ARM country officer and supply country officer, which can be cumbersome and cause delays as the team expands
  - It is not entirely clear where direct procurement function fits into the organizational structure; it will also require marketing and branding efforts that are currently not accounted for (and thus get neglected)
  - No clear ownership in current structure for GDF financial and business planning, operations and management systems (spread across GDF and STB Secretariats)

# HR AND LEGAL ASPECTS OF ADMINISTRATION COULD BE MODIFIED TO ALLOW MORE FLEXIBILITY WITHIN WHO PROCEDURES

## Key priorities

**Reduce total administrative costs and increase transparency of services received. Alternatively, increase efficiency with growing scale of operations**

**Increase flexibility in WHO hiring procedures/rules for GDF to**

- Ensure continuity of staff on short term contracts and reduce time spent on contract breaks
- Ensure ability to swiftly hire for at least a few long term positions and thus increase attractiveness to senior candidates

**Increase speed of response from WHO departments to GDF's needs (e.g., Legal and contract, treasury/accounting/finance)**

## Recommendations

- With growth in GDF's activities, negotiate with WHO for a cap on payments to WHO (in absolute terms, not as % of budget), to benefit from growing scale of operations
- Improve transparency and structuring formats in the reporting of financial payments
- Negotiate with WHO for the following (illustrative):
  - Exception to rule that short term staff needs to change department after 4 yrs (or alternatively, ensure these contracts can be transformed into long term contracts)
  - Reduce contract breaks to 2 weeks maximum
  - Secure at least 2 long term positions with exceptions to usual WHO quotas
- Negotiate with WHO to have a GDF-dedicated person for these functions in the respective WHO departments
- Further, these personnel should be directed to serve GDF from a partnership, not WHO perspective
- Precedents exist for such an arrangement

# THE STOP TB PARTNERSHIP MUST ENSURE FUNDING OF \$20-30M P.A. TO GDF FOR EACH OF THE NEXT 3 YEARS

Million USD

BOTTOM-UP PROJECTIONS

## Financial projections

	2003	% of total	2004	% of total	2005	% of total
<b>Revenues (donations, grants-in-kind)</b>	<b>15-19</b>		<b>24-26</b>		<b>29-35</b>	
<b>Cost of Goods Sold (procurement costs)</b>	12-15	81-83%	20-24	81-83%	24-28	81-84%
<b>General, and Administrative expenses</b>	3-4	17-19%	4-6	17-19%	5-7	16-19%

## Assumptions

### Drug cost

- Continue current commitments
- Continue to serve DOTS expansion plan of current countries
- ~1M USD of new commitments to new countries each TRC round
- Reflect 20% drug price appreciation in higher end

### Operating cost

- Increase in HR staff and advocacy budget
- Technical assistance proportion of drug grant increases in higher end
- WHO indirect costs decrease due to the WB Trust Fund

# THE STB PARTNERSHIP MUST ACTIVELY EXPLORE/INITIATE DISCUSSIONS WITH DIFFERENT DONOR SEGMENTS TO FUND GDF'S ACTIVITIES

	<b>Description</b>	<b>Issues to explore</b>
<div style="border: 1px solid black; padding: 5px; text-align: center;"><b>Current GDF donors</b></div>	<ul style="list-style-type: none"> <li>• CIDA, Netherlands government (« founding » donors )</li> <li>• USAID, World Bank, OSI, DFID</li> </ul>	<ul style="list-style-type: none"> <li>• Views on GDF impact and continuing alignment of GDF operations with donor objectives</li> <li>• Position vis-à-vis Global Fund</li> <li>• “What GDF would have to look like” to continue being funded by current donors</li> </ul>
<div style="border: 1px solid black; padding: 5px; text-align: center;"><b>Other TB donors</b></div>	<ul style="list-style-type: none"> <li>• JICA, other governments/ bilateral donors, public health-related foundations</li> </ul>	<ul style="list-style-type: none"> <li>• Awareness of GDF</li> <li>• Views on GDF and alignment of GDF operations with donor objectives</li> <li>• “What GDF would have to look like” to be funded by other TB donors</li> </ul>
<div style="border: 1px solid black; padding: 5px; text-align: center;"><b>Other innovative options</b></div>	<ul style="list-style-type: none"> <li>• Funders of leprosy programs, e.g. Nippon Fnd, GLRA</li> <li>• Other institutional donors interested in public health</li> <li>• Pharma companies, e.g., Novartis Foundation</li> <li>• In-country corporate donors (e.g. Shell in Nigeria)</li> <li>• Individual donors</li> </ul>	<ul style="list-style-type: none"> <li>• Willingness to divert leprosy funds to other areas</li> <li>• Current level of involvement in TB</li> <li>• Willingness to fund TB projects</li> <li>• Awareness of GDF</li> <li>• Mechanics of drug donations</li> <li>• Willingness to provide 4FDC as grants-in-kind</li> <li>• Willingness to ‘adopt-a-country’</li> <li>• Mechanisms for receiving corporate donations</li> <li>• Willingness to ‘adopt-a-country’</li> <li>• Mechanisms for receiving individual donations</li> </ul>

# GDF WAS LAUNCHED AS AN "EMBEDDED LEGAL ENTITY HOUSED IN WHO" IN 2001

Option chosen

**Legal identity**  
(for overall governance and reporting)

<b>Independent legal identity</b>	<p><b>Independent GDF hosted by WHO/ STB</b></p> <ul style="list-style-type: none"> <li>• Independent organization accountable to own decision making board</li> <li>• Subcontracting of WHO for administrative support and infrastructure</li> <li>• MoU with WHO Stop TB</li> </ul>	<p><b>Independent GDF hosted by IUATLD or KNCV</b></p> <ul style="list-style-type: none"> <li>• Independent organization accountable to decision making board</li> <li>• Sub-contracting of NGO partner for administrative support and infrastructure</li> </ul>	<p><b>Independent, stand-alone not-for-profit entity</b></p> <ul style="list-style-type: none"> <li>• Independent organization, accountable to own decision making board</li> <li>• Managing (or outsourcing) its own infrastructure and administrative support</li> </ul>
	<p><b>Borrowed legal identity, housed in WHO</b></p> <ul style="list-style-type: none"> <li>• Legally part of WHO with MoU to detail deviation from WHO norms</li> <li>• STB CB in an advisory role, final decision making power with WHO</li> <li>• GDF team part of the STB Secretariat in WHO</li> </ul>		
<b>Embedded legal identity</b>			
	<b>Housed by STB Secretariat in WHO</b>	<b>Housed by other partner</b>	<b>Standalone</b>

**Housing options**

(for administrative support and infrastructure)

# THE GOVERNANCE MODEL HAS MODERATELY SATISFIED THE NEEDS OF GDF

- Fully met
- ◐ Somewhat met
- Did not meet

## What the GDF needed at start-up

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- Well-functioning board with clear roles and representation from key TB stakeholders
- Alignment with STB goals
- Short set-up time
- Quick and efficient decision making and robust oversight

## Needs met to some extent...

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- ◐ ● Broad agreement in STB CB, WC and WHO on the need for and value add of GDF
- Committed and stable funding in first 2 years from STB donors
- Quick set-up time without a politically contentious process, by not setting up a board from scratch
- Relatively well-functioning STB CB with balanced representation, collaborative working style and focus on “*getting things done*”
- Delegation of grant review and oversight of work planning/ budgeting to WC to enable fast decision-making
- Balanced WHO role with “hands on” support at country execution level, but relatively “hands off” on governance

## ...but roles to be clarified

---

### *What GDF needs:*

- Active engagement of the governing body in setting strategic direction and clear mandate for decision making
- Strong oversight (“audit”) of financial and operational aspects, performance monitoring and succession planning
- Clear ownership of legal liability

### *However,*

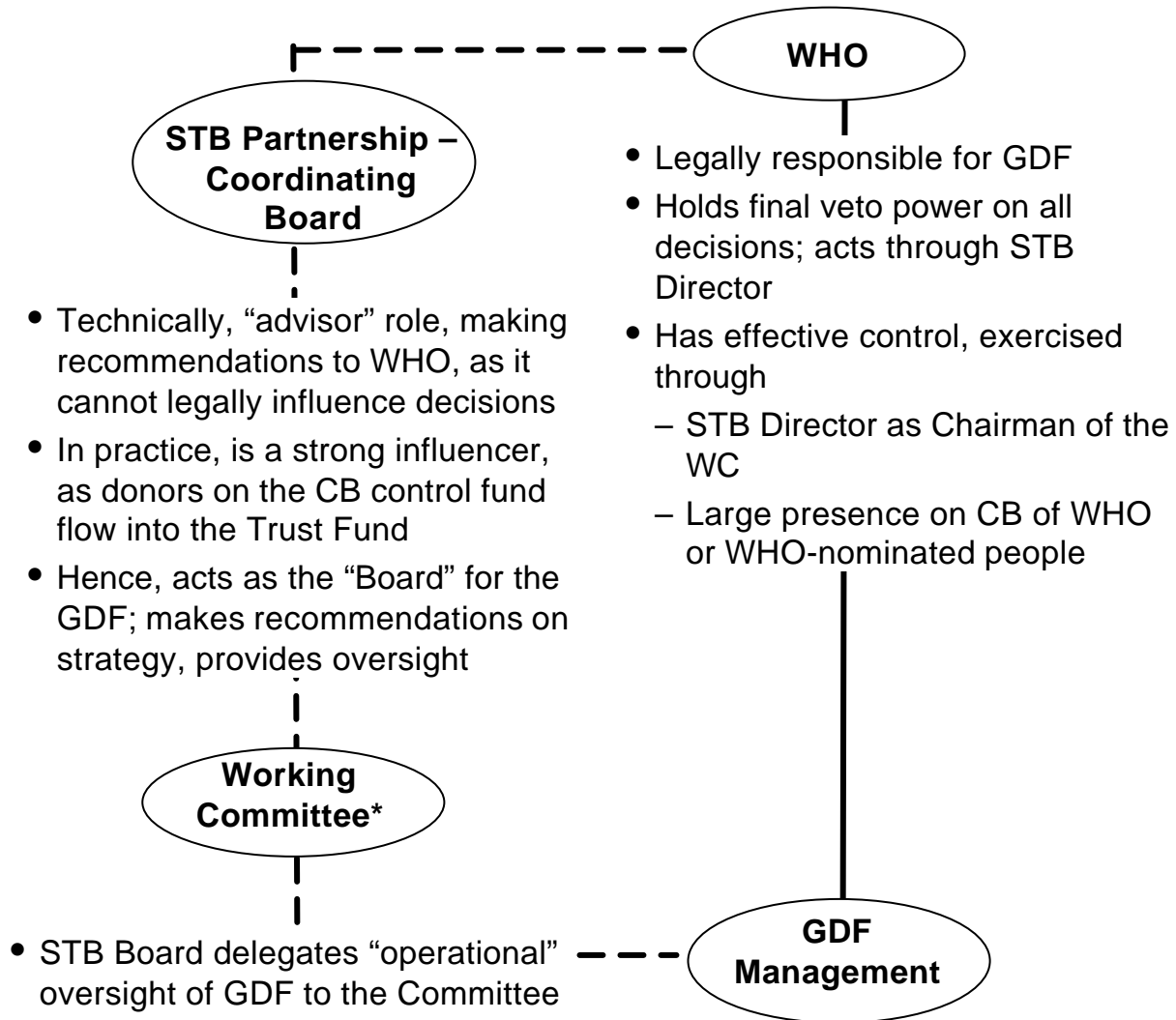
- Little consensus on GDF’s role, but limited strategic dialogue
- No clear responsibility for governance
  - Little agreement on who is accountable for the GDF. Hence, inability to foresee/ preempt problems
  - Concern about gaps in oversight, resulting in weak risk management

# CLEAR ROLES MUST BE DEFINED FOR WHO, THE STOP TB BOARD AND THE WORKING COMMITTEE

**Requirements**

- Clear “legal” responsibility for the GDF
- Strong processes for decision-making and oversight
- Appropriate balance in roles of the STB Partnership and WHO
  - The Partnership is critical to deliver the 3-part proposition
  - WHO is the only party that can have with legal liability for GDF

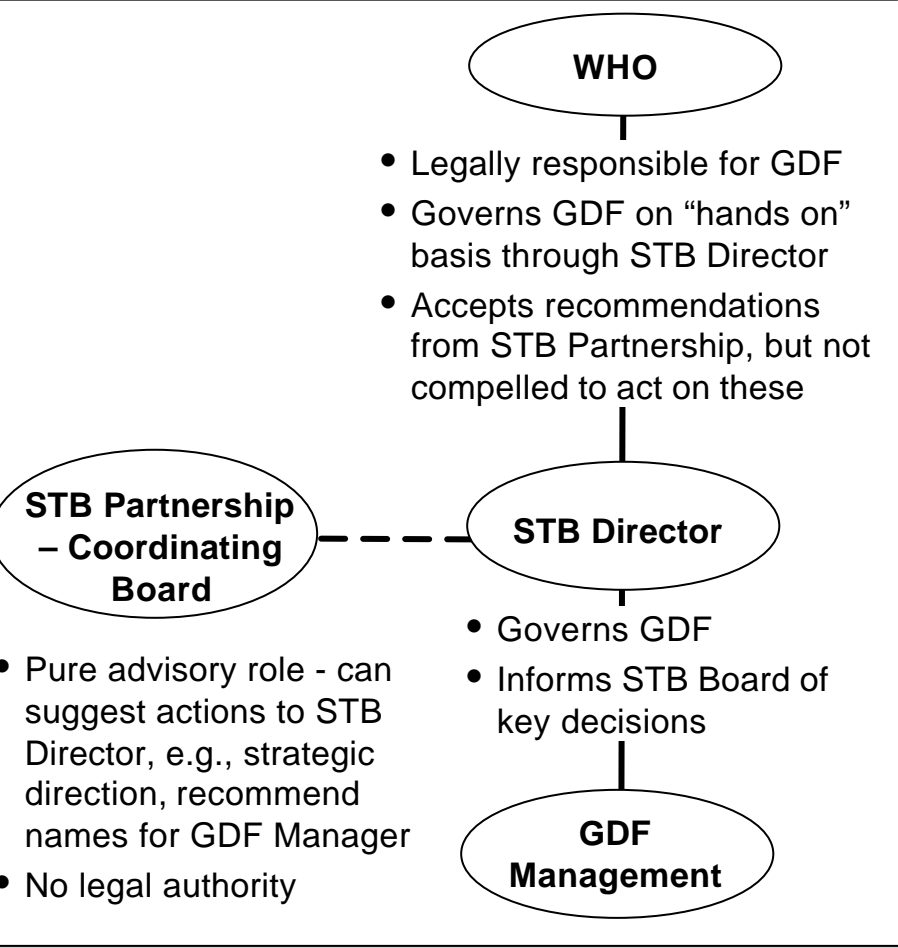
## Recommended governance model



\* The Board sets up the WC to “operationalize” its role, given the Board is a 27-member group that meets only 2X a year

# ALTERNATIVE MODELS WERE CONSIDERED AND REJECTED

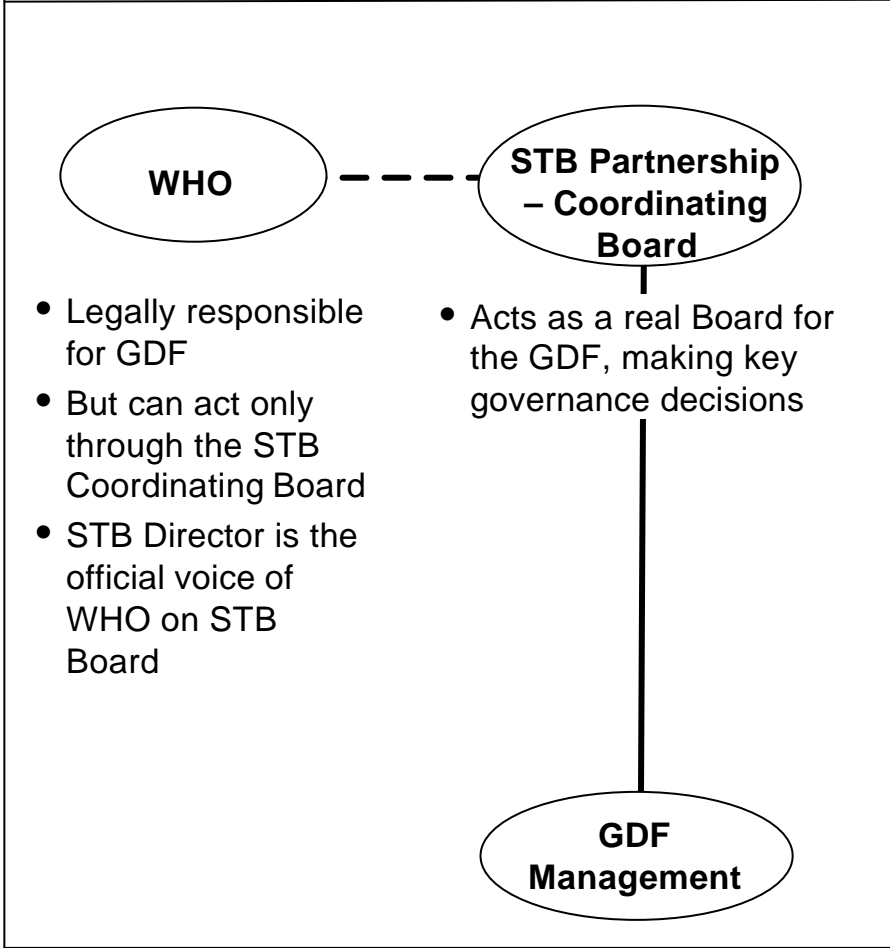
## Option 1



**Pros:** No ambiguity on governance. WHO explicitly and actively responsible

**Cons:** Little influence/role for STB partners, who could limit support and undermine effectiveness of the GDF

## Option 2



**Pros:** No ambiguity on governance - STB Partnership responsible

**Cons:** Unlikely to be acceptable or allowable for WHO if it has final legal liability. STB Board has no legal position

# POTENTIAL ROLE OF THE WORKING COMMITTEE

*ILLUSTRATIVE –  
NOT EXHAUSTIVE*

## Context

- The Working Committee is a subset of the Stop TB Coordinating Board, to “operationalize” the Board’s role with respect to GDF
- It does not replace the Board’s responsibility or decision-making powers on any GDF-related matters
- It is intended to provide closer oversight and guidance for GDF in areas that the Board is typically meant to oversee
- The WC should be a 4-6 member group drawn from the STBCB, representing groups and expertise relevant to GDF. It should meet (in person or conference call) every quarter or more often, as needed by GDF

## Potential role of the Working Committee

### **The WC would be entrusted with four roles:**

- Review robustness of the GDF management team’s actions and recommendations and ensure these are supported by an adequate fact base
- Ensure appropriateness of procedures (“audit”) for key decisions and that necessary approvals have been obtained
- Provide expert guidance in areas requested by the Board
- Flag major concerns to the Board and advise course of action, on operational and policy matters

### **The WC would execute these roles in many areas. For example,**

- GDF’s annual budget and cash flow planning, including financial projections for next three years and funding situation
- GDF’s annual strategic plan and operating plan
- TRC decisions
- Procedures for major external contracts made by GDF, e.g. procurement, supply
- Major financial transactions
- Candidates short listed for senior positions in GDF

# THE SUCCESS OF A GDF FOR ANY DISEASE REQUIRES A WELL-FUNCTIONING DISEASE PARTNERSHIP

**A supportive (“willing”) and well-functioning (“able”) partnership critical to GDF’s success...**

- **Full alignment:** Demand for the model must come primarily from the disease partnership – need agreement on importance of drug access issues, relevance of GDF model and commitment to using the GDF
- **Technical support:** Partners must be *willing* and *able* to define technical guidelines and protocols, support GDF for technical review/M&E visits and provide technical assistance to countries
- **Funding support:** Donors in each partnership will need to contribute to a core fund to support GDF’s direct grant-making role and/or work closely with other key donors and align systems

**...As seen in the case of the TB GDF and the STB Partnership’s role**

- Normative role: GDF works with WHO units like DOTS Expansion and EDM (FDC, white list)
- Fund raising: Donors on STB CB committed to STB goals finance the GDF’s activities
- In-country technical assistance: GDF relies on partners like MSH and IUATLD to provide services

*“GDF has worked well largely due to a reasonably well-functioning partnership and support for setting up such a facility. In the absence of a similar situation in HIV/AIDS and malaria, the facility will not succeed”*

• **Provision for a GDF-type model for malaria or HIV/AIDS must be driven by the respective disease partnership, which should demand, resource and house such an effort**

• **The STB Partnership neither can nor needs to provide the resources (people/money) for such an effort**

# MDR-TB, MALARIA AND HIV/AIDS ARE AT DIFFERENT STAGES OF READINESS TO USE A GDF-TYPE MODEL

**MDR-TB: Good support from GLC**

- Well-regarded body with strong technical review, credibility with donors, support of the STB Partnership
- Discussions in progress for convergence of GDF and GLC

**Malaria: RBM willing but needs to build capability**

- Interested in using GDF model for advanced anti-malarials
- However, much skepticism on capability of the current RBM Partnership - *“RBM is at least 6 months away from becoming a well-functioning partnership”*

**HIV/AIDS: Lack of clarity on partnership itself**

- Highly political and contentious area, no clarity on decision-making body
- Perceived historical enmity between TB and HIV groups; *“GDF’ for HIV is a nonstarter.. The chasm has not healed”*

Hence, each disease partnership must satisfy a check-list before it adopts a GDF-type model

- ✓ Robust negotiation process for continuous reduction in prices
- ✓ Funding from STB donors to the GDF or mandated procurement agent status with key donors

- ✓ Standardization of treatment regimens and protocols, at system/regional/country level
- ✓ Well-functioning RBM Secretariat and Partnership (e.g., clear goals, global malaria strategy, partner roles)
- ✓ Country level commitment, able program managers, plans
- ✓ Robust negotiation process for continuous price reduction
- ✓ Funding from RBM donors

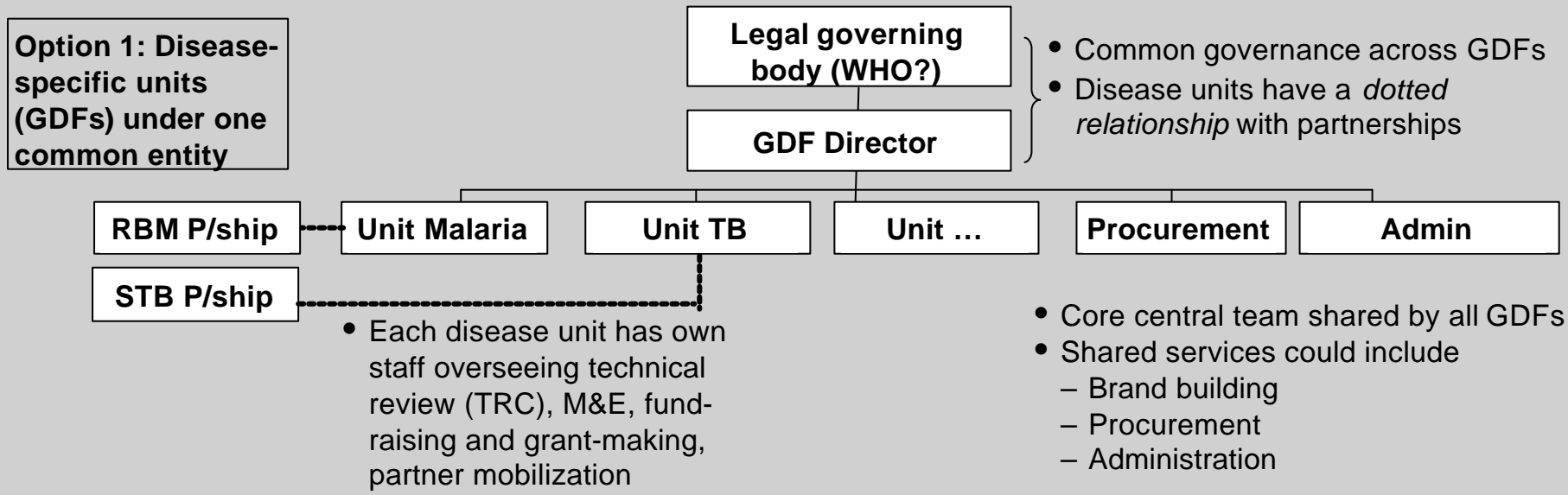
- ✓ Well-defined partnership with clear mandate on access
- ✓ Standardization of treatment regimens and protocols at system and country level
- ✓ Country level commitment, support for lifetime care
- ✓ Robust negotiation process for continuous price reduction
- ✓ Funding from key donors or mandated procurement agent status with key donors

Annex 33

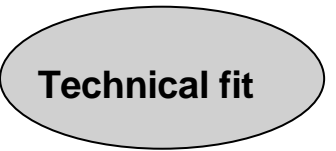

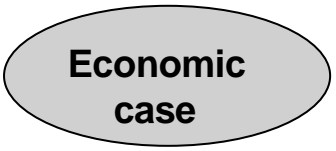

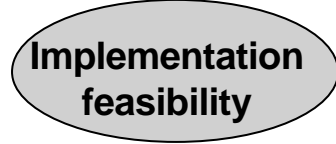
# MDR-TB, MALARIA AND HIV/AIDS HAVE UNIQUE ACCESS-RELATED NEEDS, WHICH REQUIRE SOME MODIFICATIONS TO THE GDF MODEL

MDR-TB (GLC process)	Malaria	HIV/AIDS
<ul style="list-style-type: none"> <li>• <b>More rigorous application, review and M&amp;E</b> <ul style="list-style-type: none"> <li>– Rational use more critical; limited reliable data on resistance pattern</li> </ul> </li> <li>• <b>Relatively higher funding need, but may not need own grants</b> <ul style="list-style-type: none"> <li>– GLC-negotiated price=\$1,600/ treatment on an average</li> <li>– However, may not need own grant making given preferred pricing relationship with supplier and mandated agent relationship with GF</li> </ul> </li> <li>• <b>Emphasis on advocacy and work through specialized centers</b> <ul style="list-style-type: none"> <li>– Few countries have identified and prioritized MDR-TB issues</li> </ul> </li> <li>• <b>Modified negotiation approach with suppliers</b> <ul style="list-style-type: none"> <li>– Products either patented or restricted supplier base</li> <li>– Hence, price negotiation done by GLC/MSF vs. procurement agent</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• <b>Pre-work on technical guidelines at regional and country level</b> <ul style="list-style-type: none"> <li>– No comprehensive data on drug resistance patterns; few revised drug policies</li> <li>– Standardized treatment guidelines possible only at a regional level</li> </ul> </li> <li>• <b>Ability to work with non-traditional partners (private sector, NGOs)</b> <ul style="list-style-type: none"> <li>– Treatment at community level</li> </ul> </li> <li>• <b>Modified negotiation approach with suppliers</b> <ul style="list-style-type: none"> <li>– Products either patented or restricted supplier base</li> <li>– Some supply issues different from pure generics</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• <b>Pre-work on standardization at system and country level</b> <ul style="list-style-type: none"> <li>– Need consensus and WHO-mandated treatment regimens</li> </ul> </li> <li>• <b>More sophisticated negotiation approach and political management</b> <ul style="list-style-type: none"> <li>– Highly visible political and contentious issues</li> <li>– Multi-sectoral stakeholders</li> <li>– Debate around patent rights, TRIPS, regional and local procurement/supply, drug grants, etc.</li> </ul> </li> <li>• <b>Similar issues to MDR-TB</b> <ul style="list-style-type: none"> <li>– More rigorous application, review and M&amp;E</li> <li>– Emphasis on advocacy and work through specialized centers</li> <li>– Modified negotiation approach with suppliers</li> <li>– Significantly higher funding need but may not need own grants</li> </ul> </li> </ul>




# TWO ORGANIZATION APPROACHES TO CREATE DISEASE-SPECIFIC GDFs



# DISEASES/PRODUCTS MUST FULFILL THREE CRITERIA TO BENEFIT FROM A "GDF" MODEL

Criteria	Key elements	Description
 <p><b>Technical fit</b></p>	<ul style="list-style-type: none"> <li>• Rational drug use critical</li> <li>• Standardization/innovation possible and necessary</li> </ul>	<ul style="list-style-type: none"> <li>• Technical review and M&amp;E needed to enforce right treatment protocols to minimize risk of creating resistance and transmission</li> <li>• Treatment standardization and innovations in drug delivery (e.g. packaging) important for compliance, treatment success and drug management</li> </ul>
		
 <p><b>Economic case</b></p>	<ul style="list-style-type: none"> <li>• Global pooled procurement superior to regional/local mechanisms</li> <li>• Unmet treatment demand due to drug shortages</li> </ul>	<ul style="list-style-type: none"> <li>• Buying power leverage to significantly reduce prices, ensure quality, influence product norms and stabilize demand forecasts</li> <li>• Drug shortage - due to resource gaps and/or procurement problems - a key issue in disease control</li> </ul>
		
 <p><b>Implementation feasibility</b></p>	<ul style="list-style-type: none"> <li>• Availability of partnership support in-country</li> <li>• Government commitment</li> </ul>	<ul style="list-style-type: none"> <li>• Current/potential support assured for technical assistance from in-country partners</li> <li>• Willingness to launch a national disease control program with adequate funding/people support and infrastructure</li> </ul>

# MALARIA AND HIV/AIDS LARGELY MEET THESE CRITERIA

-  Fully meets
-  Somewhat meets
-  Does not meet

**Products considered**

## Malaria\*

## HIV/AIDS\*

- Advanced anti-malarial drugs

- Drugs for AIDS-related diseases and ARVs

**Technical fit**



**Economic case**



**Implementation feasibility**



**Conclusions**



\* Commodities like bednets and condoms are not included here

# THE TB “ONE-STOP SHOP” DOES NOT FULLY FIT THE GDF MODEL AND SHOULD NOT BE A HIGH PRIORITY FOR GDF

## Diagnostics/ preventives

- Sputum cups
- Glass slides

- Microscopes
- Reagents

## Assessment

### Technical fit

- Standardization and quality not critical issues

### Economic case

- Basic products – commodity pricing
- Cheap local production often available, hence government commitment for global sourcing unlikely
- Not material cost item in TB budget

### Technical fit

- Technical assistance needed, but can be provided through partners
- Standardization helpful, but not critical. Can be coordinated through NTP

### Economic case

- Not material cost item in TB budget
- Access not an issue in a critical mass of countries (only in 4/22 HBC – WHO 2003 report)

## Recommendation for GDF expansion

### No

- Mobilize partners if identified as shortcoming during application

### Conditional yes, only if -

- Explicitly check for quality of lab facilities during application and M&E
- Work through NTP or mobilize partners, if identified as a shortcoming
- Expand on a systematic basis *only if*
  - Critical mass of countries find shortages a key barrier to DOTS implementation
  - Partner support is unavailable

# 'GDFs' FOR MALARIA AND HIV/AIDS ARE DESIRABLE AND FEASIBLE AND THE IMPLICATIONS FOR THE STB PARTNERSHIP ARE POSITIVE

**Interviews with:**

- **STB key stakeholders**
- **Other disease partnerships**
- **Potential recipient countries**

## Why GDF-model

### **Robust technical and economic case**

#### **Build on a tried-and-tested model**

- Shown proof of concept in limited time - *"GDF has actually delivered drugs in under 1 year – would rather use something that is up and running"*
- Up the learning curve on procurement
- Model is flexible to be expanded to other areas; *"GDF model can be effective for patented and commodity products"*

#### **Synergies at system and country level**

- Relatively good brand awareness of GDF in some countries
- Synergies in country networks, application and common drug management infrastructure and issues
- System level synergies include common awareness-building, application procedures, procurement and sharing of best practices

## Benefits to the STB Partnership

- Increased visibility for Stop TB could encourage new partners and donors to lend support
- Potentially improved cost-effectiveness through shared infrastructure for brand building, procurement and administration
- Potentially improved leverage for GDF brand in countries with combined scope

*And*

- No risk of loss of focus on TB or need for STB Partnership to invest own people/funds for "expansion"