



Stop TB Partnership

Coordinating Board, Osaka, 19-21 February 2002

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The Stop TB Partnership Secretariat Annual Report 2001 *Draft*

6 February 2002



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Chandra has been diagnosed with TB that had spread to her throat causing her great discomfort and difficulty in swallowing. She lives on a remote island in the Sunderbans in the Ganges delta of West Bengal. The boat dispensary brings medical aid to Amtali Island once a week.

To access a doctor and team of nurses at the makeshift clinic, patients have to walk 6-7 km because there is no transport. Chandra can only make the long journey with the help of family and friends – sometimes in heat that exceeds 37-40°C with high humidity. After her consultation, Chandra collects her medication, and then makes her way home in searing heat.

Source: Gary Hampton

THE STOP TB ANNUAL REPORT 2001

TB GLOBAL BURDEN UPDATE

TB still kills

One third of the world's population is infected with TB. Every day more than 23,000 people develop active tuberculosis (TB) and close to 5,000 die from the disease.

Each year there are 8.7 million new cases of TB and an estimated 1.7 million deaths.

If current control efforts are not massively expanded, TB will kill more than 40 million people over the next 25 years. This increase in the burden of TB is fuelled in part by the widening HIV/AIDS epidemic. Poor TB control will also lead to an increased prevalence of multi-drug resistant (MDR) TB, which is over 100 times more expensive to treat.

Global TB Burden

TB is still a disease of poverty. It disproportionately affects the poorest people in the world's poorest countries. Over 90 per cent of cases and deaths occur in low and lower-middle income countries. It is estimated that the economic cost to the poor is more than US\$ 12 billion per year. A person with TB loses on average 20%-30% of their annual household income through their illness. Poverty increases the risk of TB and TB impoverishes its victims.

Global TB Targets

If global TB control efforts continue at the current rate, the global targets approved by the World Health Assembly in May 2000 will not be met before 2013. These targets include identifying 70% of infectious TB cases and curing 85% of cases identified.

Stop TB aims to achieve these targets by the year 2005 through an acceleration of efforts at country and global levels.

Reaching these targets by 2005 and maintaining effective TB control for the five years after that will halve the global burden of TB by 2010. In the longer term great benefits will accrue: by 2020 25 million TB deaths will have been averted, 50 million TB cases prevented and the spread of TB and drug resistance halted. The social



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and economic benefits of accelerated action will also be immense, resulting in savings of billions of dollars for poor people and poor communities.

Global Progress in TB control via DOTS Expansion

Despite many challenges, TB control has made significant progress in the past year. The DOTS strategy has been adopted by an additional 20 countries since 1999 and is now in use in 148 countries. The proportion of TB patients treated in DOTS programmes has increased from 23% in 1999 to 27% in 2000.

Opportunities for Action to Eliminate TB

The most exciting opportunity for action against TB to emerge in 2001 was the development of the Global Fund to Fight AIDS, TB and Malaria. The Fund was the brainchild of UN Secretary General Kofi Annan, who has so far succeeded in gathering financial commitments totalling over US\$1.7 billion from governments, voluntary organisations and private contributions. It is vital that Stop TB capitalises on this chance to secure funding to implement the Global Plan to Stop TB, which was launched this year at the first Stop TB Partners' Forum.

TB and HIV

HIV fuels the TB epidemic in populations where there is overlap between those infected with HIV and those infected with *M. tuberculosis*. In high HIV prevalence populations, many people infected with HIV develop TB, and many TB patients are co-infected with HIV. As of 31 December, 2000, there were an estimated 36.1 million adults and children living worldwide with HIV or AIDS. Of these, 25.3 million (70%) adults and children were estimated to be living in sub-Saharan Africa, and 5.8 million (16%) in South and South-East Asia. In 2000, about 12 million HIV-infected people worldwide were also co-infected with *M. tuberculosis*. About 70% of co-infected people live in sub-Saharan Africa, 20% in Asia and 8% in Latin America and the Caribbean.

Untreated HIV infection leads to progressive immunodeficiency and increased susceptibility to infections, including TB. HIV is driving the TB epidemic in many countries, especially in sub-Saharan Africa and, increasingly, in Asia and South America. TB in high HIV prevalence populations is a leading cause of morbidity and mortality. TB programmes and HIV/AIDS programmes therefore share mutual concerns. Prevention of HIV should be a priority for TB control; TB care and prevention should be priority concerns of HIV/AIDS programmes. TB and HIV programmes provide support to general health service providers. Previously TB programmes and HIV/AIDS programmes have largely pursued separate courses. However, a new approach to TB control in high HIV prevalence populations requires collaboration between these programmes.



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HIGHLIGHTS FROM THE PARTNERSHIP SECRETARIAT 2001

2001 will be remembered for the successful implementation of several major initiatives by Stop TB. Most notably, this year saw the first Stop TB Partners' Forum in Washington, the launch of the Global Plan to Stop TB and the launch of the Global TB Drug Facility. In addition, the expansion of the Stop TB Partnership, from 75 members in 2000 to 210 in 2001 reflected the renewed interest and commitment to global TB control.

Other highlights included the meeting of the interim Co-ordinating Board, held in February in Bellagio; the celebration of World TB Day 2001 on March 24 and the increase from one to three Stop TB global events on that day; the establishment of the six Stop TB Partnership Working Groups and success of their first meetings, and the inclusion of TB and malaria alongside AIDS in the remit of the Global Fund to Fight AIDS, TB and Malaria. More details on each of these new developments will be given in the relevant sections of this report.

The Global TB Drug Facility

One tangible achievement of the Partnership this year was the establishment of the Global Drug Facility (GDF) - an innovative scheme developed in response to a call made by countries at the March 2000 Ministerial Conference in Amsterdam for new international approaches to ensure universal access to TB drugs. The GDF was initiated in 2000, developed in collaboration with partners and launched on World TB Day, March 24 2001. Initial funding came from the Canadian International Development Agency (CIDA) and subsequent support has been provided by the Government of the Netherlands and USAID. The GDF aims to treat up to 11.6 million patients over the next five years. So far the Technical Review Committee of the GDF has recommended 16 countries for GDF support from a total of 25 applicants, equivalent to drugs to treat around 550,000 patients. Following the first supply of drugs to Moldova in October 2001, shipments have also been made to the Democratic People's Republic of Korea, Myanmar and Congo Brazzaville. The GDF has already spent £7.8 million on TB drugs for these countries and those receiving drugs in early 2002.

Drug prices have fallen substantially, with a full course of treatment now costing less than \$10 – including regimens using four drug fixed dose combination tablets.

THE GLOBAL PARTNERSHIP TO STOP TB

The Stop TB Partners' Forum 2001 also saw the first Stop TB Partners' Forum, an assembly of representatives of the organisations which make up the Partnership. The Forum convened for the first time in Washington, DC from 22 to 23 October



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2001. Nearly 200 participants attended from 18 high burden countries, 9 developed countries, 9 multilateral partners, and 60 other organizations. The Forum's mandate is to meet every two years in order to consolidate partners' commitment to TB control and the Partnership's objectives, reinforce high level political commitment to stopping TB, exchange information and identify new challenges in TB control, create and exploit opportunities for advocacy and communications activities and social and resource mobilisation, and to review the progress made in the preceding two years. The two main outcomes of the first Partners' Forum were the endorsement of the Washington Commitment and the launch of the Global Plan to Stop TB.

The Washington Commitment

The Washington Commitment is a declaration endorsed by all Forum participants. It initiated a countdown to targets for the following 50 days, 50 weeks and 50 months (see box 1 below.) So far the Washington Commitment has received more than 60 endorsements from governments and partner organisations.

Box 1 Countdown to 2005

50 Days

- all high burden countries to finalise national DOTS expansion plans

50 Weeks

- to achieve a global DOTS case detection rate of at least 35%;
- to establish interagency coordinating committees in all high burden countries;
- the GDF to provide TB drugs to at least a million additional patients

50 Months

- to achieve a global DOTS case detection rate of at least 70%
- to achieve a DOTS treatment success rate of at least 85%;
- to develop and scale up effective responses to TB/HIV and MDR-TB;
- to develop the Global Plan to Stop TB for the years 2006-2010

50 Years

- eliminate tuberculosis as a global public health problem

The Global Plan to Stop TB

The second major outcome of the Forum was the launch of the Global Plan to Stop TB.

With support from the Open Society Institute, the Stop TB Partnership Secretariat and Partners in Health successfully developed The Global Plan to Stop TB during the year 2001.

The Global Plan sets out the strategy, priorities and resource needs necessary to stop TB. Its investment section is a business plan which can be taken to private and public sector donors to show that TB control is a sound investment. The stated targets of the Global Plan are:



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- By 2005: Detect 70 per cent of estimated new active TB cases and cure 85 per cent of cases detected
- By 2010: Reduce the global burden of TB (deaths and prevalence) by 50 per cent from year 2000 levels.

Among the Global Plan's strategic objectives are:

To expand DOTS in order that all people with TB enjoy accurate diagnosis and treatment;

Adapt this strategy to meet the emerging challenges of HIV and drug resistance;

Improve existing tools by developing new diagnostics, new drugs and vaccines; and

Strengthen the Stop TB Partnership so that proven TB control strategies are effectively applied.

This requires the building of a strong partnership which upholds principles of inclusiveness, transparency and responsiveness among all partners – but with a particular focus on TB endemic nations. The Global Plan's mandate also involves moving beyond purely medical TB control and emphasizes the necessity of contributing to poverty reduction and health sector strengthening. To that end, resource mobilization remains a vital objective in the fight to Stop TB.

Governance of the Partnership – the Co-ordinating Board

One hundred and forty partners involved in the consensus building process during 1999-2000 have endorsed the governance mechanisms of the Stop TB Partnership. This framework, including the Stop TB Partnership structure, the functions and composition of the Partners' Forum and Co-ordinating Board, and the Stop TB Partnership Secretariat, was endorsed at the Partners' Forum.

The Co-ordinating Board represents and acts on behalf of the Partnership and consists of representatives selected from among different groups of stakeholders. In its composition, the Board reflects the diversity of the partnership — scientists, policy-makers, financial donors, field/country level programme managers, the private sector, civil society and those concerned with advocacy and communications. The Co-ordinating Board meets two to three times a year and guides the work of the Stop TB Partnership.

Expansion of the Partnership

In 2000, Stop TB had 75 partners. Today that number has increased to 210 individuals and organisations. Among new organisational members are ActionAid, Merlin UK, The Royal Tropical Institute and Refugee Trust International. Many of



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these new partners attended the first Stop TB Partners' Forum in October and provided support for the development of the Global Plan to Stop TB.

Working Groups Update

Stop TB has established six Working Groups to ensure that TB control initiatives are implemented in a co-ordinated and efficient manner. The six Working Groups focus on the following areas of activity:

- DOTS Expansion,
- TB/HIV
- DOTS Plus for MDR-TB,
- New TB Diagnostics
- New TB Vaccines
- Global Alliance for TB Drug Development

DOTS Expansion Working Group

The essential services needed to control TB, based on diagnosis and treatment of infectious cases and incorporating the essential management tools, were developed by the International Union Against Tuberculosis and Lung Disease (IUATLD) in a few developing countries in the 1980s. These services were subsequently packaged by WHO as the DOTS strategy (see Box 2 below) and promoted as a global strategy in the mid-1990s.

Box 2: The five components of the DOTS strategy

1. Government commitment to sustained TB control activities
2. Case-detection by sputum smear microscopy among symptomatic patients self-reporting to health services
3. Standardized regimens of six to eight months' treatment for, at a minimum, all confirmed sputum smear positive cases, under proper case management conditions, including directly observed therapy (DOT) at least for the initial two months.
4. A regular uninterrupted supply of all essential anti-TB drugs.
5. A standardized recording and reporting system that allows assessment of treatment results for each patient and of the overall performance of the TB control programme.

Many countries that have applied DOTS on a wide scale have witnessed remarkable results. Transmission has declined in several countries: in Peru, for example, the drop in incidence had been approximately 6.5% per year over the past decade. Mortality has fallen: 30,000 deaths have been averted each year in districts implementing DOTS in China. Drug resistance has decreased: in New York in the 1990s, the prevalence of TB drug resistance fell by 75% following aggressive interventions to improve patient management.



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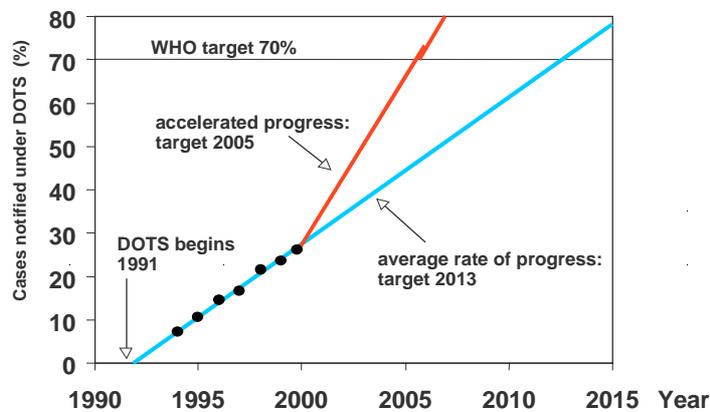
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Unfortunately however, DOTS expansion is not proceeding at a rate rapid enough to achieve the global targets for 2005 in time. At the current rate of expansion, these targets will not be reached before 2013 (see below). Millions of TB sufferers worldwide are being denied effective treatment because DOTS is not available in their area. A massive scaling up of current efforts and innovative ways of motivating all possible contributors to the fight against TB are necessary in order to meet the 2005 targets.

Projected case detection under DOTS Without accelerated expansion, World Health Assembly targets will be reached in 2013



The Global DOTS Expansion Plan

On May 16, 2001 WHO released *The Global Dots Expansion Plan, Progress in TB Control in High-Burden Countries, 2001*. The GDEP is a strategic planning document that describes how countries and their partners can work together to expand DOTS. This document provides a framework from which regions and countries may expand coverage by, firstly; developing well thought out regional strategic plans, and, secondly; by facilitating the development, monitoring, and implementation of country-specific medium term plans. Thirdly it calls for the establishment of interagency co-ordinating committees (ICCs) which bring together all partners, both technical and financial, to implement the agreed upon plan under the stewardship of the country's government.

Recent analysis for the GDEP has provided estimates of the resources required to achieve the global TB control targets. The analysis suggest that an average of around 1 billion US\$ per year is needed for the 22 countries with the highest number of estimated cases of TB, otherwise known as the "high burden countries" or HBC.



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Provisional work indicates that an additional 0.2 billion US\$ per year is needed in low and lower middle income countries beyond the 22 HBC. At present around 70% of required funding is available from HBC government and around 5% from donors. The funding gap for the 22 HBC and low and lower middle income countries is up to around 300 million US\$ per year.

Great steps forward have been made in DOTS Expansion during 2001. At the end of 2000 only 12 of the 22 High Burden Countries had even begun to develop sound country plans. By the end of 2001, 16 of the HBCs had produced comprehensive DOTS expansion plans and 6 had plans completed but not yet translated or under development.

2001 was a year for the preparation of plans and identification of resource gaps; the emphasis in 2002 will be on implementing these plans for DOTS expansion.

According to the 2001 Global DOTS Expansion Report, progress in TB control has remained slow in most of the 22 high-burden countries. Of the 22 HBCs, only Peru and Vietnam achieved WHO targets for case detection and treatment success.

However there were some notable successes; Peru was in 2001 officially removed from the list of HBCs and Mozambique took its place. With 33% of the world's active TB cases, India is nevertheless making astounding progress against the disease.

India has achieved an expanded DOTS coverage from 9% in 1998 to 40% in 2001 and is now treating more patients with DOTS than any other country in the world.

Working Group on TB-HIV

Mmatsela was only 14-years-old when a friend of her Aunt's raped and beat her and infected her the virus that causes AIDS. Newly arrived from her parent's home in Botswana, Mmatsela was a helpless child with nowhere to turn. Every time she tried to leave, the boyfriend only beat and abused her further. Following her escape, Mmatsela was diagnosed with TB. Knowing the link between TB and HIV/AIDS her father insisted she go for an HIV test. That too, came back positive. As it turned out her aunt's "friend" had also sexually attacked two other women. Both later died of AIDS-related illnesses.

Today Mmatsela is 19-years-old and suffering the stigma of being both TB and HIV positive. Although both parents are very supportive, her younger brother treats her badly, accuses her of infecting the household and insists she has brought shame on the family. She is forced to eat from separate utensils, sleep on her own bed linen and dry herself with a separate bath towel. Despite all of the odds however, she yearns for a time when she may work and live independently.

Mmatsela comes to the Hospice three times a week for treatment, support and understanding. Thanks to two months of TB medication, she feels much better and is now approaching her life with a renewed sense of hope and purpose.

September 2001, Holy Cross Hospice, Gaborone, Botswana



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The goal of the Global Working Group to control TB/HIV is to reduce the burden of TB in high HIV prevalence populations. The Working Group, coordinated by WHO, is one of the six working groups established under the auspices of the Global Stop TB Partnership. This first meeting of the Working Group in April 2001 was a crucial step in harnessing and coordinating global efforts to provide a more effective response in decreasing the burden of TB/HIV.

The Working Group has endorsed a new strategic framework to decrease the burden of TB/HIV. Working Group partners are operationalising this framework. They are promoting collaborative activities between TB and HIV/AIDS programmes in key countries, building on field experiences such as the ProTEST Initiative. This Initiative is examining the feasibility and cost-effectiveness of linking voluntary counselling and testing for HIV with interventions for TB and HIV/AIDS prevention and care. Partners are also collaborating in the development of field guidelines for phased implementation of collaborative TB and HIV programme activities. In 2002 they will be focusing on a series of proposal development workshops for four African countries which will be organised by WHO in collaboration with USAID and the Centers for Disease Control (CDC).

Working Group on DOTS-Plus for MDR-TB

Initiated in 1999, the Working Group on DOTS Plus for multi-drug resistant (MDR) TB, conducts and oversees pilot projects based on the Guidelines for Establishing DOTS-Plus Pilot Projects for the Management of MDR-TB prepared by the Scientific Panel of the same working group. The DOTS-Plus Working Group aims to improve access to second-line anti-TB drugs for DOTS-Plus pilot projects, primarily through the Green Light Committee (GLC).

The Working Group is collaborating with the pharmaceutical industry to combat MDR-TB. As part of this collaboration members of the pharmaceutical industry have agreed to provide preferential prices to DOTS-Plus pilot projects. The Green Light Committee as a subgroup of the Working Group reviews projects applications and determines whether projects can benefit from the preferential prices. To date, it has reviewed twelve potential DOTS-Plus projects for participation in the pooled procurement of concessionally priced second-line TB drugs.

The GLC approved eight applications including those of Estonia, Latvia, the Oblasts of Tomsk, Kemerovo and Orel Oblast (Russian Federation) for access to concessionally -priced second-line drugs. Applications from Mexico, Nigeria, and India are currently under review.



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The Working Group has also published two guidelines: Guidelines for Drug Susceptibility Testing to Second-line Drugs for DOTS-Plus and Guidelines for Establishing DOTS-Plus pilot projects for the management of MDR-TB. Group members have also established a short and long-term pooled procurement process for second-line drugs.

Other achievements include negotiating for price decreases of up to 94% in treatment regimens for MDR-TB; the implementation of training sessions for 10 countries applying for access to preferentially priced drugs, and the provision of technical assistance to the Philippines, Latvia, Estonia, Peru, Costa Rica and Russia. In addition, the group is building capacity for DOTS-Plus through site monitoring visits to pilot projects in the Philippines, Estonia, Latvia, Tomsk, and Peru. To date, the approved DOTS-plus projects serving over 2,000 patients are already operational and benefiting from substantial drug price reductions.

Working Group on TB Drug Research and Development

The Global Alliance for TB Drug Development (GATB) acts as the Working Group on TB Drug Research and Development. It operates as a not-for-profit, public-private partnership organisation with offices in Brussels, Cape Town, and New York. Launched in October 2000, the Alliance offers a unique approach designed to accelerate the discovery and development of new drugs to fight tuberculosis.

On the eve of World TB Day 2001, the GATB presented research data and stressed the urgent need for new drugs in the fight against the global tuberculosis epidemic. The data presented highlighted some alarming trends – particularly the rate at which people are becoming infected with both HIV and latent TB infection (LTBI). The report showed that the number of people with TB-HIV co-infection (10.7 million in 1997) is rising rapidly and thereby increasing the number of active TB cases. They stress the need for research into shorter treatment regimens for both latent and active TB. The report identified some further neglected areas within TB drug research and development and will seek to address these issues by forming partnerships with the pharmaceutical industry and public research organisations.

GATB members also announced preliminary research findings demonstrating that an anti-TB drug that significantly reduces the period of treatment could be highly profitable. This announcement was the result of two comprehensive studies undertaken by the Global Alliance: *The Scientific Blueprint for TB Drug Development* published in April, 2001 as a supplement to *Tuberculosis*, a journal which focuses on the latest research advances relevant to tuberculosis control and elimination; and *The Economics of TB Drug Development*.



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The Alliance produced the latter report to provide the data required to make informed decisions regarding TB drug development investment on the part of industry, philanthropic foundations, and global financial and health organisations. Released in May 2001, *The Pharmacoeconomics of TB Drug Development* demonstrates that an anti-TB drug that reduces the period of treatment to 2 months could capture much of the total annual worldwide market for TB drugs, currently worth up to US\$470 million. This estimate however, could be considered conservative. According to the Alliance, a drug that not only reduces treatment to 2 months but is also effective against MDR-TB and dramatically shortens the treatment for latent TB infection (particularly in patients who are HIV-positive) would capture a substantially larger market. The Alliance's goal is to have a new drug registered by 2010 and available in developing countries by 2012.

GATB and stakeholder organizations also organised dozens of scientific events focusing on TB drug development worldwide. These included a meeting in Cape Town in February 2001, the Inaugural Gordon Conference in USA in June 2001, and a symposium at the IUATLD annual conference in Paris in October 2001.

Working Group on New TB Diagnostics

More than one hundred years after its inception, the microscopic examination of sputum is still the only widely available diagnostic tool for TB in most developing countries. This technique has several pitfalls, not least of which is an inability to diagnose non-infectious TB cases, coupled with the difficulty of maintaining well-equipped laboratories in developing country settings. The upshot is that only a small fraction of TB patients are quickly and accurately diagnosed leading to increased morbidity, impediments to DOTS expansion, the erosion of faith in public health care services and most importantly, continued transmission of infectious TB.

Progress is being made, albeit slowly. There are now more than 50 private sector enterprises involved in developing TB diagnostics. Like GATB, the working group functions as a "virtual shop" exchanging information and keeping abreast of new developments through the Internet and by email.

Working Group on New TB Vaccines

For years health experts have recognised the necessity of improving on the current BCG vaccine. Effective in the prevention of several serious forms of TB in children, BCG does not fully protect against pulmonary TB in adults.

A series of new developments in microbiology, genetics and biotechnology however, have substantially contributed to our knowledge of *M. tuberculosis*. For the first time



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since the advent of BCG, researchers now believe that a new and effective TB vaccine can be developed by 2020.

So far, The TB Vaccines Working Group has met once - on June 9 2001 in Geneva. This date was selected to coincide with the WHO Global Forum on TB Vaccines Research and Development. The purpose of the Working Group meeting was to recommend next steps and determine a framework for the development, clinical study and introduction of improved TB vaccines for the global community. The Working Group, which also functions as the TB Vaccine Initiative Advisory Committee for WHO (TBVIAC), then met to establish its agenda and formulate a 5 year plan for activities to promote and facilitate TB vaccine development.

THE GLOBAL TB DRUG FACILITY: up close

The benefits

It is estimated that at least 10 million TB patients will benefit during the first five years of the facility's operation, with an additional 45 million served after ten years. By 2020, 25 million TB deaths will have been averted, 50 million TB cases prevented, TB prevalence reduced by 75 per cent and its incidence by 50 per cent. One beneficial spin-off will be the strengthening of medical infrastructures as a whole – including the addition of large numbers of trained staff, improved diagnostic capacity, treatment and practice, sustainable monitoring systems and rationalized procurement systems ensuring a ready supply of affordable drugs.

Development of GDF prospectus

A Core Technical Group was created in November 1999 to finalize the GDF prospectus and to develop recommendations on the scope, principles, objectives and governance of the GDF. The prospectus was presented at the Stop TB Co-ordinating Board meeting, held in Bellagio in February 2001. The scope and principles of the GDF were endorsed and interim operations were approved with funds made available by CIDA. It was agreed that the GDF would be managed by the Stop TB Partnership secretariat in WHO for an initial period of two years, to be followed by an external evaluation. Since then further funding has been provided by the government of the Netherlands and USAID.

How it works

As a time-limited body (with a life span of 10-15 years) the GDF is designed to meet short term needs for TB drugs to support DOTS expansion, giving countries time to develop and strengthen local drug procurement capacity. Countries were invited to apply for GDF support in early 2001, and a technical review committee (TRC)



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comprising 12 independent experts in TB control was formed. The GDF held two rounds of applications and the TRC appraised application forms from 25 countries. To date 16 applications have been accepted for support, with two awaiting a final decision. The total and the first GDF drugs were delivered to Moldova in October 2001 (see box 3 below). In 2001 only country governments were eligible to apply but it was agreed in late 2001 that NGOs would also be able to apply for support, and a direct procurement mechanism was also established to enable countries and organisations to buy drugs through GDF mechanisms and at GDF prices but using their own finances.

Box3 Moldova and the GDF

Moldova is a country with a population of around 4.29 million. Since the early 1990s the number of new TB cases per year has increased dramatically. This, coupled with socio-economic difficulties has contributed to shortages of high quality TB drugs in the country. Drugs supplied through the GDF will treat nearly 4,000 TB sufferers in Moldova.

Drug procurement and quality assurance

The GDF purchases drugs to be supplied as grants-in-kind through limited international competitive bidding from pharmaceutical manufacturers who meet pre-qualification standards governing experience, quality and capacity. In 2001, the contract was awarded to MEG/Svizera. In the first year of operations the GDF has relied on the pre-qualification process of Stop TB partners involved in international procurement of TB drugs – the GDF is now developing a long term and more robust approach to pre-qualification, with the aim of publishing a white list of approved manufacturers and products.

Following a competitive bidding process, the GDF contracted with UNDP/IAPSO for procurement services. IAPSO has been responsible for tender management, procurement, pre-shipment inspections, laboratory analysis, shipping, insurance and communications with recipients, and has also developed a web based ordering and tracking system (www.stoptb.unwebbuy.org) to enable GDF recipients to follow their order on the internet.

Quality is a key concern for the GDF, and it has contracted with SGS for pre-shipment inspection and independent laboratory analysis of each batch of drugs before dispatch to recipient countries.



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THE ROLE OF ADVOCACY AND COMMUNICATIONS IN STOP TB

Stop TB's global advocacy is focused on mobilising political will, financial and human resources and increasing the involvement of a broad range of multi-sectoral partners including the UN, bilateral agencies, NGOs, foundations, industry and research institutions. Media activities are centred on raising public awareness of TB as a major killer and the necessity of its control. Press and media events exploit new media and are generally organised in tandem with the publication of new available data and other TB control events and initiatives. In 2001, other advocacy activities focused on linking TB to various policy developments, such as to HIV/AIDS, human rights, and sustainable development. Thus communication remains a key instrument driving the global movement to Stop TB.

During the biennium 00-01, Stop TB established a sound communications infrastructure – including a monthly electronic communiqué, weekly web-alerts, quarterly Stop TB newsletters and the Stop TB website, which is updated daily. The website had over 50,000 hits in the second half of 2001.

The Stop TB quarterly newsletters in 2001 focused on the following themes:

- June 2001: World TB Day, sent to over 5000 interested parties;
- September 2001: TB/HIV newsletter, sent to the Stop TB Partners and to UNAIDS network
- December 2001: DOTS Expansion Newsletter, sent to Stop TB partners and national and local level organisations working in TB.

Communications Activities in 2001 – Highlights of Events and Meetings

During the World Health Assembly in May 2001, Stop TB partners launched The Global DOTS Expansion Plan with Peru Minister of Health Dr E Pretell Zarate, in attendance at the press conference.

At the first UNGASS meeting in New York in June, the International Union Against Tuberculosis and Lung Disease (IUATLD) organised *TB – The forgotten companion of HIV* in a side-event aimed at informing delegates and the media of the often-overlooked link between HIV/AIDS and TB.

At the First Stop TB Partner's Forum in Washington on October 21, advocacy materials included three informational videos. They are:

- The Global TB burden and the Stop TB Partnership response;
- The GDF, a mechanism for securing a consistent supply of high-quality TB drugs;
- TB among the HIV positive;

ProTEST, a possible approach to implementing collaborative programme activities to tackle TB people living with HIV/AIDS



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WORLD TB DAY 2001

"DOTS: TB cure for all" was the theme for World TB Day held 24 March 2001. The theme was chosen to highlight access to TB treatment and cure for all as integral to the exercise of fundamental human rights – that is a TB patient's 'right to the highest attainable standard of health' as set out in the WHO charter.

To that end, The Stop TB Partnership called for increased access to TB treatment for all and emphasised three points:

TB treatment is a human right,

New mechanisms are needed to increase access to treatment, and

New drugs are vital to ensure the long-term sustainability of effective treatment.

For the first time World TB Day 2001 featured a wide range of events organised by different Stop TB Partners throughout the world.

Key events included:

- On March 16 2001, His Grace Archbishop Desmond Tutu initiated World TB Day events in South Africa
- During March 2001 the South African government, in partnership with other stakeholders, inaugurated the opening of the Tyger Trade and Training Centre (TTTC), a multi-sector initiative that aims to treat both the economic and social problems associated with TB by job skills training, media and public awareness campaigns and community mobilisation.
- On March 20 in New York Médécins sans Frontières sponsored a panel discussion on "Defusing the Time Bomb: The World's TB Crisis" at City University in New York.
- On March 21 in Washington DC the National Council for the Elimination of TB and Stop TB launched the "Omnibus Control Act of 2001" and the Global TB Drug Facility (GDF) in a joint event.
- During the week preceding World TB Day 2001, The Global Alliance for TB Drug Development held a press conference in Brussels to announce the publication of the executive summary of *The Economics of TB Drug Development*.
- On the eve of World TB Day 2001, the Bill and Melinda Gates Foundation awarded US\$ 10 million to the United Nations Development Programme/World Bank/WHO Special Programme for Research and Development in Tropical Diseases (TDR) to facilitate the development of new tests for tuberculosis diagnosis.

Other communications efforts for World TB Day focused on:

The production of various materials, such as the Stop TB series on Guidelines for Social Mobilization



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The production of World TB Day Highlights 2000 and 2001, in addition to background documents and a series of videos on current issues relating to TB for the Stop TB Partners' Forum.

LOOKING AHEAD - 2002

2001 saw the achievement of global co-ordination among the Stop TB Partners which was reflected in the success of the Partners' Forum in Washington and the endorsement of the Washington Commitment by all participants. It also saw the production of the Global Plan to StopTB, setting out the resources and actions needed to meet the targets set for 2005. This means that Stop TB goes forward into 2002 able to turn for support and expertise to a wide range of individuals and organisations, including but also going beyond those who have traditionally worked against TB. The Partnership also now knows exactly what is required in order to meet the 2005 targets. It is vital that Stop TB use our partners to the full and that the partners stand by their commitment to contribute to the fight against TB. With the Partnership Secretariat at its centre, this network of partners can scale up efforts against tuberculosis and leverage available funding in innovative ways.

The launch of the GDF is a concrete example of how new mechanisms can be implemented in a short period of time. Only eight months after its inception the facility had delivered drugs to three countries. More such innovative responses to specific problems in TB control will be necessary if the 2005 targets are to be met, since changes in the way we tackle TB as well as increasing the scale of current efforts are necessary to reach these goals on time.

2001 was a year in which the groundwork was laid for implementation of further very large DOTS expansion schemes, effective responses to TB/HIV and MDR-TB and a medium term communications and advocacy strategy for Stop TB. 2002 will see the focus firmly shifted from planning to implementation and therefore will be the first year in which we see a real acceleration towards the 2005 targets. There is still a long way to go but the 2005 targets can be met if all partners work together effectively in the ways agreed in 2001.