

**Minutes 8<sup>th</sup> Stop TB Partnership Coordinating Board Meeting**  
**3 May 2005 -**  
**Addis Ababa, Ethiopia**

**1) Opening**

Round of introductions.

**Chair :** introductory comments - turning the tide of TB control. We are in the process of winning but are not there yet. Africa remains the biggest area of concern.

**LG Sambo:** welcome comments – importance of TB in Africa, of the presence of the Board and of linking TB with the HIV epidemic.

**Minister - Tedros Adhanom:** Welcome to Ethiopia, the country of 13 months of sunshine. Ethiopia is one of the 22 high burden countries with 124 000 cases a year. Aggravated by TB/HIV co-infection. We are in the process of containment and reversal of the dual epidemic. A joint response is being instigated with sharing of information and experience. 20 hospitals are scaling up for ARVs. DOTS treatment is available in all 126 hospitals, 590 Health Centres and 1533 clinics. The remaining 645 clinics will eventually receive the service. We are also accelerating the expansion of health centres with special emphasis on community DOTS and social mobilization. Ownership by communities is key. Additionally, the national Health Service Extension programme will put 25 000 health extension workers extra into the system at community level in the next couple of years. Finally, this year we are making a proposal for Global Fund. We welcome partnership help and support in making that a success.

**Q&A**

**Baudouy:** how will Ethiopia accomplish the scale up?

**Adhanom:** Aim is to achieve Universal primary health care by 2008 through the Health extension package service. Additional health workers at a rate of 2 workers by village. Building a formal health infrastructure at village level will enable us to reach blanket coverage. Adding on a comprehensive IEC approach will let us cover a wide range of health topics - 16 packages will be covered in total. Finally with skills transfer to the local community and innovative ways of using existing clinics we will strive to reach the MDGs and build health infrastructure.

**Teixeira/Cheshire:** how can affected communities and TB patients increase their involvement?

**Adhanom:** There is a central joint steering committee. The CCM has representation from community and patients. The idea is to strengthen the partnership between the various players. A Community Committee decides on who get HIV treatment – the

committee is made up of patients, women and youth groups. The question of how to involve patients is more complicated. Once cured, are they eligible?

### **Adoption of the Agenda/Minutes**

**Chair:** DOTS plus working group request – Wednesday pm. **Agenda adopted.**  
Espinal – The Secretariat has tried to address all recommendations, notably with relations to a Heads of State Strategy, ISAC and Global Plan.

**Castro motions, Freire (2<sup>nd</sup>)** – *minutes/action points adopted.*

### **1) Election of the Chair - Nominating Committee**

**Chair:** Volunteers accepted with thanks but there is a need for balance on the nominating committee. Secretary Bilenge requested his term be cut short in view of domestic commitments. Bilenge supports a system of renomination.

*Therefore the Chair proposes a Chair and Vice Chair nominating committee.*

- 1) Freire volunteers - joins.*
- 2) The Board will co-opt an additional member for the Nominating Committee from the South from in or outside of the Board*
- 3) Nominating Committee – Chair and Vice Chair – to aim to achieve balance in the proposals for the November meeting.*

### **1) Appointment of the Vice Chair**

*Motion – Approved.*

### **2) Annual Progress Report 2004**

**Espinal:** Regarding Governance – CB meetings were organized in India and China, along with the New Delhi Partner’s forum. An external evaluation was completed. The Executive Committee was set up. The Secretariat provided support for coordination and growth. At the end of 2003 there were 250 members. This had grown to 303 members by the end of 2004. 4 new national partnerships were established. Tools to monitor and evaluate these are being development. With regard to working groups – Global plan (2006-2015) process has started. ISAC imitative started with support to China, Indonesia, Kenya, Pakistan and Uganda. Five Working Groups met in 1994. A&CSM working group was established. ACSM activities focus on information products, media and political events, website re-designed. Country communications – building on the USAID country initiative. ACSM also held a workshop for R5 proposals early in 2005. GDF reached 4 million treatments in the 4 years it has been operating. A

financial management plan has been operationalized, a Trust Fund has been established at WHO with special rates of PSC. We have for the first time established reserves. Income increased to US\$ 23 million annually but expenditure decreased because US\$ 9 million received at the end of the year. These funds have been earmarked for ISAC, IAPSO, GDF.

**Freire:** This is positive as taking all contributions of 2004 in mind there is a net increase for GDF.

**Castro:** The fact that WHO is also facing financial constraints. As much of the Stop TB Partnership activities depend on proper financing of WHO, it is key that the Board is informed of any funding crisis which may be pending.

**Raviglione:** The financial position is especially worrisome as a result of the US dollar exchange rate - this has led to a reduction in value of 25% in salary costs. This threatens normative functions but the pressure is being shared with TBP. Unspecified contributions are not increasing for STB, with effect on GLC and TBP among others. Of particular note is the increase in the cost of staff.

**Sambo:** AFRO confirms that the Region is not seeing any budget growth for Regional or country support.

**Billo:** The fall in the value of US\$ is effecting all partners. It should be noted that in a crisis this may lead to less support from partners to the Secretariat.

**Broekmans:** The extra overall funding requirement for TB globally needs to be mentioned and in particular the struggle to find funding for TA.

**van Schooten:** 2004 Netherlands proposal from WHO is still being negotiated. These funds should partially relieve the budgetary constraints.

**Small:** Request WHO to report specifically on its budgetary situation at the next Board meeting.

**Chair:** In view of the constraints, donors need to rise to the challenge of increasing funding to the partnership – go back to governments and seek extra support. There needs to be clarity on where we stand with problems on funding.

*Annual Progress Report 2004 - adopted after discussion but without amendment.*

### **3) MOU with WHO**

**Koek** – Adaptations to WHO rules are required to enable the Secretariat to carry out the Board approved work plan. In 2001 an MOU was signed by the Chair of the CB and DG of WHO. This is now out of date. A revised MOU would look at clarifying legal aspects – including the legal status of the Secretariat being derived from establishment within WHO, use of logo, letterhead, website. Administration – such as the structure of Secretariat within STB department, work-planning approval process between the Board and WHO. Recruitment - proposals for special adaptations such as reduced contract breaks and waivers on term limits, quotas and staffing levels. For Global Drug Facility – management procedures and reporting to the Board, details on the tendering process and direct procurement of drugs would be laid down. The new MOU would clarify the status of the Trust Fund with reduced PSC rates. Finally the validity of the new MOU –

would, in principle, be indefinite Amendments would be by mutual agreement. Key question is do we need a new MOU? If yes, how do we proceed?

**Castro:** Will WHO be amenable to the changes?

**Koek:** For some amends yes but not all. Will need to negotiate.

**Raviglione:** WHO has not yet seen this draft of the MOU but recognizes that there is a need to formalize initiatives of this type. WHO is keen to harmonize agreements with the wide variety of partnerships. Sections on the recruitment of Ex. Sec should be OK with WHO. However PSC is to be reviewed at the end of the year. The Board should note that the quota issue will be difficult as it depends not on WHO per se but on member states pursuing balanced representation in the WHO secretariat.

**Koek:** Indeed, this is a negotiating positions. The PSC negotiations in particular are extremely important.

**Castro:** The Board needs to be clear on what are we prepared to give up if we empower a team.

**Broekmans:** Strongly support the idea of further development of this MOU and a good idea appoint a committee as uncomfortable with only a GDF MOU.

**Chair:** **There is consensus on the need for an MOU.**

**Billo:** In the interim partners need to help out with recruitment to give secretariat the flexibility to appoint etc.

**Shah:** Can we amend the existing MOU?

**Koek:** Yes, in principle but the amendment will be much broader than the original MOU.

*Chair: In summary, we will try to negotiate a new MOU; our fall back position is an amendment to the existing MOU. Propose Irene as Chair of the Committee. Giorgio also accepts a nomination. Propose the Committee come to the Board with a negotiating mandate. Please note that the Trust Fund PSC rates are vital.*

#### Next Steps

- 1) Yes – proceed with concept of MOU
- 2) Committees – Irene, Giorgio and one more (Mario – offer to be the liaison with WHO) Kaisar Ali Shah – offered to look at the legal aspect of the draft MOU and revert to the Secretariat.
- 3) Proposed mandate presented to the Ex. Committee.
- 4) Agree fall back position with a minimum set of amends
- 5) If we fail in this, it is understood that the status quo will stand.

#### **4) Engaging World Leaders Strategy**

**Broekmans:** This strategy aims at a systematic approach to reaching out to world leaders. The problem we face is a lack of high profile spokespersons for TB. TB has generally followed a bottom up approach, led by TB professionals. There is a need to reach out to the highest echelons of government leadership. With international charisma and leadership, we will be able to reach new audiences. The Strategy approaches the

problem by signalling the need to plan outreach in 2 groups - among high burden countries and donor or potential donor countries. We need to reach out to leaders of under performing countries, notably . Nigeria, South Africa& Russia. After this we must try to engage leaders in donor country communities – take advantage of World Health Assembly resolution, global plan awareness and follow up to inter-ministerial conference. This will set the framework for a supportive political environment.

**Castro:** Need to further compliment a world leaders strategy with a plan to engage a wider group of TB community “champions” from key countries.

**Friere:** This has identified some great strategic advocacy objectives. This is a historic time in TB, a time to build a movement in TB control. As new tools for TB control become available and are developed, there is an opportunity to maximize our positioning for fund raising as a worthwhile investment in the future. Would welcome this being better reflected in the strategy.

**Koek:** To do this we need to look at the RM plan and pick up work already done from earlier.

**Roscigno:** How do we engage African leaders? What kind of language do we need to use – need strong arguments on what messages we need to deliver to leaders on the cost of TB to their countries so that they become champions. Can we provide that messaging? Perhaps the World Bank can assist?

**Baudouy:** Agreed the Bank could help try to formulate - the type of message is critical. For HIV it is easy. TB has nothing really new to say. What kind of branding do we need for leaders? Top leaders understand the problem. Perhaps of greater concern is at the mid-level of management. There is very little translation of national policy to implementation.

E.g. Ethiopia has a very decentralised system. For funding, the Ministry of Finance is critical. We have to be realistic and target the key players rather than just the top players.

**Cheshire:** Ambitious and strong strategy but will the suggestions work and have an effect at national level. What can be done at national level? National level mobilization should be done in unison and harmony with this strategy.

**van Schooten:** What kind of message and branding will be selling? Could we combine efforts with HIV and strengthen links with UNAIDS. We should see the strategy in the context of the global replenishment conference. Also setting our messages clearly for the corporate sector – what kind of impact do the diseases have on the investment potential and economic development in the country?

**Small:** Global Plan is a phenomenal advocacy opportunity - advocacy should link with that.

**Teixera:** Message should build on the success of the partnership. Good results are being achieved. However feel that we need to involve civil society much more. Great opportunity would be the International Conference taking place in October in Lima on people living with AIDS and caregivers.

**KA Shah:** This strategy have very political overtones which could create ownership problems. Be careful to not be too political. There is a need to approach through administrative systems (TB programmes) which are neutral. Community awareness can be increased if the administrative systems buy in better.

**Jintana:** How will the strategy be implemented? Time magazine “has a man of the year” Can we link the strategy with identifying champions for the Global Plan who will take the plan to its logical conclusion in 2015. Need to identify people who are valued beyond borders – without countries or religion.

**Nantulya:** This is a strong strategy but would want to see something more operational. Structurally the TB community needs to build civil society e.g. in Kenya only one proposal for TB was put forward during the last round.

**Castro:** We don't need singular champions that work everywhere but appropriate champions by country or region – everywhere.

**Pasakorn:** Ideally, TB would establish communications upstream and downstream and the strategy would also involve the media.

**Billo:** Agreed that we need champions everywhere. In Mexico – nurses become champions. Need to get buy in from people so that they make TB control work as a part of their every day lives.

**Freire:** Appreciate the need for realism but TB struggles from a middle child syndrome. We as a community should stop trying to be politically sensitive. Support a strategy that is ambitious and forward thinking.

**Carter:** Agree with Maria. We are placing a lot on the Global Plan. This will involve a 2 pronged strategy that involves the direct high level approaches outlined in this strategy. It also requires back up at national and local level – outreach. We should take opportunities such as WEF. Strongly support concept the concept of a of new inter-ministerial conference. We should also look at ways of reaching the new World Bank President and tie this strategy in with the EU and African strategies being discussed later on.

**Baudouy:** Agreed we should not be shy but we should not look at TB programmes in isolation. We should demand full funding but do it in an intelligent way. Need to access the Ministries of Finance. Would welcome a delegation to the Bank to discuss further.

#### **Chair: Summary of tactical principles**

- 1) World leaders strategy is good but we also need a **broader** strategy: to involve civil society, corporate, media, patients to achieve the many champions principles.
- 2) Our advocacy strategies should be **joined up**; linking with other opportunities; HIV and sector wide approaches.
- 4) National advocacy and policy chance is not the only story – the realities of advocacy and its importance for **implementation** should be included - administration issues.
- 5) Clear **messages** and branding should be developed.
- 6) Full needs for TB have to be explained – but **not TB in isolation**.

There should also be an amendment to include research and new tools in point 2. Need to ensure a positive message on the usefulness of new tools on accessing patients that we have not addressed so far. Maria will support new language.

Need for funds – drop international community as this should also reflect domestic increase in resources.

**Nantulya:** World Bank - clear costing required. Can it be provided?

**Chair:** Yes it can be done. The Bank has agreed to do a study which the Secretariat will consider funding on the socio-economic implications of TB?

**Espinal:** Need a proposal from the Bank

**Baudouy:** Fine, Bank can facilitate the preparation of a report.

**Van Schooten:** Do not forget discussions of the Global Plan.

**Nantulya:** There should also be strong reference to poverty reductions strategies etc. as part of the joined up strategy

**Van den Borgh** – This strategy is strong but perhaps overly ambitious – can we prioritize these opportunities?

**Raviglione** – Focus should be on G8, EU summit. Linking with the development of champions – esp. participation at the G8? PM of Ethiopia will participate at the G8. Can he act as a TB champion?

**Espinal:** We should also stress the importance of the African Union and their upcoming Summit of Heads of State. At this point, would welcome Mr. Thomas from the AU Secretariat.

**Basstanie:** NEPAD – importance of integrating TB into the NEPAD agenda. HIV/AIDS strategy with UNAIDS is being launched next month. TB has not really done this.

**Nantulya:** There is also the need to focus on the replenishment conferences

**Stewart:** In relation to the G8 drafts of communiqués are being developed. A SHERPA meeting is taking place on the 10<sup>th</sup>/11<sup>th</sup> of May. Important that we get in there with good information. Currently they are looking at the earlier replenishment numbers for shortfalls. Consistent approach to the SHERPAs by donor representatives would be important.

**Baudouy:** The approaches should place new drugs and new diagnosis tools as front running arguments. New TB drugs would fit exactly in the supply of products with wide public good for advance purchase agreements. Millennium Summit missing.

**Koek:** Agree G8 needs a cohesive strategy. We can not go with just a pitch for money.

**Raviglione:** Support the need to reconsider the importance of the Millennium Summit – TB needs to be in the statements. Specifically get mention in goal 6 for the MDGs.

**Carter:** scale up in TB and linkage with HIV in Africa.

*Chair: Support the strategy, eventually we need to go wider but want to focus on some specific priorities for next steps with who will take the lead. Joanne Carter to lead a small group in preparing a few slides with a brief overview for further discussion tomorrow. Group to include Marcos Espinal, Billy Stewart, Peter Small, Lucy Chesire, Paul Nunn & Louise Baker.*

#### **4) EU Strategy**

**Broekmans:** The strategy represents a systematic approach to engage the EU. TB has traditionally seen the EU as an impenetrable fortress. Strategic issues – political and

social environment, focus on Eastern Europe and funding for TB control and research. EU generally reflects a wider lack of concern for TB control in Europe. However, progress is being made as WHO Copenhagen recently being declared TB a regional emergency. In terms of approaching the EU there are 3 main areas of work and joint collaboration: In the **health** sector, specifically with the new European CDC, in the **development** sector with trying to influence the direction of the new Programme of Action on HIV, TB and Malaria in the context of external action. It should be noted though that in the programme of action there is no specific identification of EE as a particular problem and EE appears to fall between the cracks. Finally, there is the **Research** DG with their ambitious new framework.

Next steps and action plan: mapping of partner agencies and resources available to help implement the plan, regular briefing of officials, country level of engagement of EU delegations, a possible Ministerial conference, adoption of EU proposals through budgetary and political processes, the upcoming UK presidency and development policy paper, eventually leading to an event for WTBD 2006 and/or Coordinating Board meeting.

**Castro:** € is the right currency to appeal for donations at the present time. From the strategy it is clear that there needs to be regularly briefings to policy makers of the reality of TB in European countries. The EU should be acting from enlightened self-interest.

**Tupasi:** European TB is very important as eastern European has the highest burden of MDR TB and may miss the MDGs as a result. The bulk of funds required for MDR TB are needed for EE.

**Roscigno:** Great that this strategy has clarified the complicated picture of working with the 3 DGs at the Commission. The question is which players should be involved? For MDR TB we need to engage the European Development Bank. Development DG has produced some very visionary documents and we must engage with the POA more. On Research – not a single TB project – we should encourage partners to respond to calls for proposal.

**Billo:** IUTLD has secured €6 million from the EU for TB/HIV and clinical trials - liaison resources in Brussels were critical to this. It should be noted that there is real hostility between WHO and the EU.

**Small:** Grassroots approach to the EU work best. Notable success working with Programme Officer Lang on research issues.

**Young:** EUCTP (Clinical Trial Partnership) – needs to be involved.

**Raviglione:** EUCTP – invite them to next Board to present Research portfolio at next Board.

**Van Schooten:** In the short term it is probably true that the EU is impenetrable. Interesting to look not just at development but also at Health and Research. Will take this back and discuss with their national ministries about how we can convince EU member states to think and talk about this problem in their back yard.

**Nantulya:** Clear the EU has many pots of money but could liaison is critical to accessing this money.

**Broekmans:** There is a proposal for Stop TB Europe partnership being discussed by the

ICC that would build on the statement of the WHO Regional Director.

**Carter:** Research appears to be a prominent opportunity. Lots of important partners based in Europe and we should start with a mapping of partner agencies and key resources available to us in order to take forward EU advocacy.

*Chair: In summary; we agree that this is a timely initiative and taking the opportunity of WHO declaring TB a regional emergency we should endorse the strategy and work to raise the profile of TB in Europe and among key policy makers with a special focus on research. There will be a need of a high level mission to the EU later in 2005. It is clear that some form of presence in Brussels appears to be critical. The Partnership should try to find and fund a liaison officer position with regards to the EU.*

*A special temporary taskforce will be established (reporting to ACSM working group): Maria Freire to (TB alliance to investigate hosting the liaison office). The group will consist of Jaap and Martien from KNCV Douglas Young, Nils Billo, Stefan Van den Borgh, Kitty Lambreghts. Mario will involve the Regional office - Richard Zleskis.*

*Carter: Louise Baker should also be involved, having worked in the EU will be an asset. Results will nominate a liaison person to the taskforce.*

## **5) High Level Missions**

**Espinal:** 3 parts to this session about high level missions. Approve the guidelines, approve and please sign up for which high level missions you are interested in participating in as outlined on the draft calendar and feedback from the Indonesia HLM.

**K Shah:** HLM are designed to engage prominent partners - to be a powerful political tool. There is a need to distinguish between HLM and Tech review. The purpose of the guidelines is to make HLM more effective by ensuring a process for agreeing composition, preparation & securing a request from partner country. TOR should be clearly established and there should be a technical review and briefing (public and private) prior to the HLM. Attached is the proposed calendar. Possible amends are welcome. There has already been a proposal to bring forward the Nigeria mission.

**Broekmans:** HLM to Indonesia undertaken in combination with the Technical Review. Mario, Marcos, Irene (replaced) and I participated. Purpose was to certify progress towards global targets and to engage the new Minister of Health. Rapid scale up has taken place and case detection above 50%. TB services have been decentralized and now depend on local funding allocation. The HM enjoyed intense engagement with the MOH. The Minister of Health was invited to the next Board meeting in Italy. The HLM also briefed the Commission for Social Welfare at Parliament – which was a critical and very productive meeting.

**Castro:** why/who are we keeping the briefing from?

**Espinal:** The private briefing paper is for Board members prior to the mission; anything controversial that members need to know that can not be said in public.

**Castro:** Can we imbed and do a technical review in conjunction with HLM?

**Jintana:** What is the difference between TRC and HLM? Impact and cost effectiveness?

**K Shah:** HLM reaches the highest level: beyond what the bureaucracy can say or

commit to..

**Kaisar Ali Shah:** Objective to differentiate the two needs to be clearly defined. The purpose should be to find or create a space (fiscal and policy) to develop TB.

**Chesire:** Winstone Zulu/Lucy Chesire visit. Is that a HLM?

**Faruque Ahmed:** Bangladesh – part of the reason for incomplete success is a lack of political commitment. Senior management and the Minister of Health are not engaged. Would welcome the HLM to Bangladesh during October.

**Nantulya:** Cost effectiveness. Linking with Coordinating Board meeting? Is the calendar that is proposed realistic? Questions – what happens if a country says no?

**Baudouy:** Indeed, it is critical to manage expectations. A country expects funding as well as advice. People tend to be extremely polite during HLM. Are we prepared to become more direct? There is a need to be careful of taking into account implementing agencies perspectives and linking objectives with field level outcomes etc. Term HLM – is it appropriate or are we being too arrogant?

**Freire:** There are many types of missions GDF/MDR/new tools missions may work better in certain situations.

**Basstanie:** There are the joint technical health sector reviews. Could TB be mainstreamed within this framework?

**Chair** – HLM are not a general solution but only for specific situations and countries. We do not go empty handed. Funds and resources (GDF, ISAC, Fidelis) are available as funding mechanisms for particular support and of course there is Global Fund (where govts have not asked for sufficient resources).

**Espinal:** May and November are both Coordinating Board meetings. The value of HL missions is not only money and technical it is more political. Focus on the political points that need the attention of the Minister. HLM are good to encourage countries to reach for the goals and remind them about TB. The Board decides, the country and or an NGO can also request. We can change the title of the missions. Certainly the policy/advocacy missions by Winstone and Lucy are invaluable. The mission make up varies depending on the target audience. The guiding principles were written a committee appointed by the Board and adopted by the Ex. Committee. At this stage, we are looking for a final endorsement but can include amends.

**Koek:** Mission should be focused on a particular issue - normally a policy issue. We could try the title Coordinating Board Missions or Policy missions.

**Chair:** CIDA is in favour of arrogance. HLM is a good title – opens doors to meet with important world leaders.

**Van Schooten:** High Level is to do with the goal and outcome of the mission and fundamental in the achievement of the plan.

**Nantulya:** HLM to be specifically related to a policy issue or concern or are they for general awareness raising with prominent people.

**Castro:** What do we need to accomplish? Fit the language to the accomplishment.

**Chair:** decision: The Board approves and endorses the guiding principles - subject to clarification: on advocacy – we should be doing more; clarity on who decides – Board or country requests but we can not go if the country says no. Make it clear the service orientation of the HLM. Ensure clear objectives are defined before anything is kicked off. Now, to look specifically at the calendar. Can we combine Italy with the EU?

**Espinal:** Could be possible but others meetings outlined are vital.

**Koek:** No point in insisting on an EU HLM until the plan is in place and being implemented. But welcome if possible.

**Kaisar Ali Shah:** Agreed, there is a need to create awareness and an informal democratic dialogue.

**Raviglione:** Missions have been going for a long time. Needs change all the time – so the Board must be flexible. On that point, Nigeria has failed to secure GFATM support twice in the past. Lack of political commitment means Nigeria will fail again. The last proposal failed because the ministry did not change the proposal as suggested. Can we bring forward the HLM to before the round 5 decisions – so they won't fail again? .

**Castro:** Prioritization needs to take place on the basis of easing suffering. Target countries where the problem is greatest and impact most needed.

**Van Schooten:** Nigeria needs careful analysis. Millennium Development Goals Summit should be included by we need to prioritise.

**Thomas (African Union):** TB is high in the political agenda. Reflected in statements by Heads of State. AU should be informed about problems and we should work through the Assembly so that problems can be overcome. A HLM to the AU Summit in July in Tripoli, Libya would be welcome

**Chair:** On behalf of the Board would like to accept the AU offer and will follow up tomorrow during our discussions on Africa.

**Raviglione:** Battle on TB will be won or lost in Africa. AU be co-opted onto the Board/partnership for the next couple of years to represent the Continent.

**Chair:** Mario - please propose this at the Africa session.

**Small:** Surprised to hear AU did not about the problems of political commitment for TB in Africa. How can we work better with them?

*Chair : Our work on better collaboration with the AU starts tomorrow.*

*AU Summit, Libya in July – ADOPTED*

*Nigeria: bring forward to before Round 5.*

*Millennium Development Goals Summit - tentative*

*Secretariat to come up with purpose statement for each mission by day 2 and circulate a sign up sheet.*

## **6) Global Strategy to Stop TB**

**Raviglione:** Taking the strategy beyond DOTS 2. Nothing particularly new in what we propose but packaging needs to bring everything together. This discussion will lead into the International Standards of Care debate. All designed to build on 1995 DOTS. The Global Strategy aims to ensure care for ALL TB patients; **quality DOTS**; meeting the MDGs; responding better to the needs of constituencies; reflect innovation; consistent with Global Plan; link with poverty and the hard to reach.

DOTS does not explicitly address the newly emerging issues (HIV, MDR, hard to reach, research). All elements need to be reflected in the strategy as is the clear evolution that

has been undertaken already since 2001.

Pursing quality DOTS expansion – improve case detection and cure through effective patient-centred care for all, especially the poor (update the original 5 points). TB/HIV, MDR TB, health systems strengthening - HR, engaging all health providers, patients and communities and enabling R&D.

Request to the Board - endorse the principles, recommend improvements, endorse the plan for stakeholder engagement, consider options for launch, Review progress at November CB

**Castro:** Welcome and endorse the principle of a global strategy - would like to see a ten point strategy for Global Stop TB.

**Van Borgh:** Very happy with private sector involvement in the process but people in countries think that we are still in 1995 and view DOTS in these terms. For this plan, it is important that the roll out and how it will work at country level are well worked out.

**Van Schooten:** The Global Plan should come first and then we can linking up TB with MDGs and tackling poverty.

**Koek:** Endorse Mario's proposal in that it addresses the challenges. Approve the ten point component as it supports the evolution from DOTS.

**Chair:** Feel there is a need to keep the DOTS brand, ensure that the poorest is included in the BIG titles to the strategy - not as an afterthought. Ensure that the Global Plan and the new strategy is in sync.

**Raviglione:** thank you for the endorsement. Will adopt the ten point approach but modernise the five elements of DOTS.

**Kaisar Ali Shah:** There are legal implications of empowering patients and strategies, the strategy needs to have country and regional specificities.

**Small:** In terms of the roll out; rather than TB specific peer review, a Lancet article co-authored by HIV/AIDs and health systems experts would be more effective.

**Van Borgh:** A distribution mechanism is needed to get it right to the consumers.

**Jintana:** Can we use community mobilization vs. empowering. What are the non medical interventions?

**Nishijima:** Does the strategy focus on case detection and the need to detect more cases. This is where the strategic approach should start.

**Cheshire:** Empower the patients and communities is better than community mobilization. However, resources are required to empower the community and will need to be made available if this type of strategy is going to work. As a side note but a very important one - please can we remove the term TB suspects.

**Baudouy:** Welcome the development of a global strategy. The role of various partners (i.e. norms and standards – WHO) needs to be clarified – what happens at global, national level would be critical. Set of principles such as these is a real step forward but costing and benchmarking are needed. At the High Level Forum meeting prior to the MDG meeting; Gates expressed an interest in providing support to ensure coordination of health systems strengthening components.

**Van Schooten:** This could be critical to ensure that we tackle new challenges particularly in Africa.

**Nantulya:** There may be a need to flesh out the key issues on what is preventing us

from achieving things; objectives, milestones, costing.

**Raviglione:** WHO's role is part of most elements. It is the strategy that WHO will promote with the distribution of responsibilities among partners. We intend to stick with current indicators. Roll out – will continue with input from MOH and other stakeholders. Case detection and notification in particular needs to increase engagement of the private sector. Global plan will identify resource requirements. Country specificities and prioritisation will take place at country level.

***Chair: summary of decision***

*Endorse the concept of proposal.*

*Roll out the plan.*

*Establish a ten point approach.*

*Highlight poverty & remove stigmatizing labels.*

*Global plan 2 and the strategy should be synchronised leading to a costing and implementation plan being put in place.*

*Endorse the process for getting feedback and input.*

*Eventually this should be not just be the WHO strategy but should be the Stop TB Global Strategy that we all promote.*

**6) International Standards of TB Care**

Moved to Wednesday.

**7) MSF Statements**

**Gillies:** Thank you to the Secretariat for the opportunity to state what MSF thinks. Welcome the approaches that you are taking in the new global strategy. It was an interesting experience to have had many of the concerns I aim to voice being addressed and considered just before my presentation.

Achievements of DOTS include bringing order to chaos, regimes, procurement, political problems. But there are limitations, notably on DOTS branding and from our perspective it isn't clear which DOTS is being implemented in the field. It is essential that the new plan is recognised and is implemented in the field. From our own experience of 13, 000 patients in 52 projects – some stand alone or in conflict zones, but also in Ethiopian nomadic groups; the programmes look good but show significant exclusion. For example up to 49% of cases have show some resistance. Do we do drug sensitivity tests straight away? With regards to DOTS - MSF is not convinced it is essential. 2 year treatment is very difficult. With ARVs the evidence is that with good ARV counselling, that patients do understand the need to stay the course. On drug supply – there are no WHO pre-qualified drugs for children or 2<sup>nd</sup> line drugs. We need drugs and a regime that works for patients. Data collection is very difficult even in MSF own projects. So in summary we face brand ambiguity, patient exclusion, drug resistance TB and supply issues. We consider it import to recognise the difficulties and advocate to have them addressed.

Somewhat surprised in the documents that there is a perception that MSF is having a campaign against DOTS. MSF is not having a campaign against DOTS. Position of MSF is coming directly from field operations and patients. We don't and won't keep quiet about constraints and challenges. Our aim is to improve treatment and reduce exclusion. We believe that we play an important role in translating the problems based on field reality and generating a public discourse. A successful programme should not have 2 million people dying of TB. In Asia we may see a decline in TB cases. However, MDR TB and TB in Africa means we need more diagnostic tools, shorter treatment, diversify adherence strategies and vaccines.

**Castro:** Can we co-opt you into support the new strategy?

**Karam Shah:** The difference in position appears to be one of communication rather than divergence.

**Small:** Before we get too worried about a perceived communication problem – would urge Members to consider the advantages of an inside outside strategy? Would be keen to work with MSF on new tools development and research, engaging MSF into moral and human rights aspects of TB? Is there also a fundraising opportunity here – can MSF help?

**Cheshire:** Welcome the presentation. Particularly your call for new drugs that are patient centred. There is clearly something failing with the GLC if we don't have drugs for MDR TB. How do we get this process moving?

**Gillies:** To be clear, MSF has a humanitarian focus. We are not really able to endorse a strategy. Prefer to represent the patients from a field experience. We want to get to the patients will are missing. Not sure about our capacity to work with you on new tools we are doing research but on even less well recognised diseases.

**Kaisar Ali Shah:** There is a lack of awareness about TB. MSF playing a valuable role particularly in those areas that experience huge movements of people.

**Nantulya:** Agree that while Direct Observation of Treatment is a sound principle it does not substitute for a solid behavioural change communication strategy.

**Blanc:** National Programme Managers do the analysis every day, identifying low performing district and putting in place ways of reaching the marginalized. What worried me was when you said you have not had a campaign against DOTS, when I read in the newspapers “DOTS does not work” - e.g. Liberation article. Clearly we agree on most of the technical issues but when it comes to the communication there is a discrepancy.

**Gillies:** This is only one article in Liberation. It is unfair to focus. But MSF does say that DOTS does not work for all patients - this is a statement of fact. Otherwise 2 million people would not die.

**Stewart:** Much of this about branding and packaging of DOTS – DFID consultation through WHO is sponsoring a stakeholder analysis; would be happy for MSF to be part of the consultation.

**Roscigno:** This is philosophical but comes down to the way in which we externalise constraints; MSF and Partnership externalise differently. We believe there is a need for MSF to think about the statements that may undermine and damage things. We can do more confidence building approaches with MSF through working together on projects to build trust.

**Billo:** There is a difference between what your communication and technical people say. For us it is sad that every year they come up with the same thing that undermines national programmes.

**Nantulya:** Is this getting us anywhere?

**Chair:** We will stick to the speakers list and try to wind the debate towards a conclusion. .

**Carter:** Beyond new tools, it is not clear what are the current alternatives? But the partnership is oversensitive to the criticism. Have we at the partnership underplayed the problem? I believe that the advocacy that MSF does is good for us.

**Castro:** Agreed, the example of the HIV/AIDS activists and importance of the inside outside role they played in generating demand for action was invaluable. Eventually we were able to build bridges.

**Gillies:** Hopefully this meeting has been an opportunity to improve the discourse; certainly has been valuable for me and I hope that we can continue to work together on a technical level.

**Chair:** Thank you. Think this has been a productive discussion. With violent agreement and creative tension. I think that you will find no argument here that it is unacceptable for 2 million people die of a disease that is perfectly curable. We will continue the dialogue.

## **8) New Drugs**

**Freire:** The New tools Working Group is something that the Board has supported consistently. The group is made up of 80 individuals from around the world. We aim to find new TB regimens – shorten and simplify the regimen and improve treatment. Our realistic aim to shorten the drug therapy to 1-2 months (10-12 doses in the medium term) and eventually, in the longer term, looking at a 7-12 day course (but this is not possible based on current science). The Working Group pipeline is based on a standard process of discovery (when we think we have a compound), pre-clinical stages (testing on animals) and then full clinical trials. Currently we have 5 clinical trials with novel compounds. For the first time in 40 years; we have the possibility of developing 7 new drugs for TB and could have a rational new therapy.

The challenge for the working group is to systematically get through all the stages – to achieve novel new therapies that are commercially viable by 2015.

**Gillies:** Why is the message this year more promising? Are you considering drop-outs?

**Freire:** Our original approach had been only to replace one compound. Only when we started putting the global pipeline together – last year we had an epiphany and started noticing that we may move away from old compounds all together. Johnson and Johnson have come on board with their molecule. Yes – drop-outs are counted – we are building in a large fall out rate during triage.

## **8) New Vaccines**

**Young:** Vaccines generally work by boosting the immune response. TB works differently. BCG gives some level of protection but TB is not a simple VPD. However we believe it should be possible. According to Global Plan 1 we aimed for five trials by 2005. 3 complete and 2 will be started during 2005. The new vaccines all add something to BCG. In Global Plan 2 our aim is by 2015 to have a safe, effective licensed vaccine available at sustainable cost. We need to see that it is safe amongst all target groups and phase 3 clinical trials should start by 2009. We are developing a parallel track strategy for pre and post exposure vaccines. Post exposure vaccine targeted at people carrying the organism.

We estimate we need 20 candidates to come up with 2 vaccines. The vaccine budget for global plan 2 is US\$ 3 billion with a US\$ 1 billion current shortfall. The role of the working group is to facilitate the pipeline and promote global access. We need to include an analysis on vaccine impact post 2015 in the Global Plan calculations. Beyond this we need to get community buy in for TB vaccines - starting with targeted focus groups (recently did the same for bovine TB vaccine).

**Koek:** Do you have a target efficacy for the vaccine identified yet?

**Young:** No there are no targets set as yet.

## **9) Public Private Mix**

**Uplekar:** TB care needs to be local and patient centred. Many patients fall below the cracks and as community we need to reach out to all patients. There are a very wide range of health care providers from traditional healers, private hospitals etc that may not fall under the DOTS systems. Patients also move between providers. This makes our evaluation all the more difficult as we don't get information from this chaotic system.

On the ground, PPM aims to achieve improved case detection, improve treatment outcomes, enhance access and equity and reduce burdens on patients. PPM has implemented over 45 projects in 20 countries. Assessment suggests that of the 20 000 patients evaluated under PPM programmes, treatment success rates are at 80-90% etc. Case studies from India, China, Indonesia, Bangladesh, and several African examples show PPM saves costs for the patient and ultimately can become more sustainable.

Request to the Board to support the recommendations from the subgroup on PPM DOTS that met in Manila.

**Karam Shah:** PPM is invaluable for reaching the poor. Poor are the people who go the private sector.

**Castro:** That appears to be counterintuitive?

**Natulya:** We need to get diagnostics down to local level as well.

**Roscigno:** Rapid diagnostic tests by 2010 could be used by unskilled workers.

**Koek:** Agree that poor use private sector and they are our key concern.

**Van Borgh:** Outreach to the whole health infrastructure is vital to ensure accessibility issues are properly achieved.

**Nantulya:** This is important if you are assessing cost sharing for example in Uganda; the higher costs in the public sector are a disincentive to patients.

**Billo:** In the private sector we need proper treatment, follow up and reporting.

**Raviglione:** PPM sub group is essential to TB control. Should be considered as a working group rather than a SUB group.

**Baudouy:** PPM can be seen as a health systems issue. Accreditation, user fees etc. – we should aim to strategically link this to the health systems strengthening approaches.

**Chair:** *The Board endorse the recommendations of the Manila meeting and requests the secretariat to consider upgrading the sub-group and place this on the agenda for the next CB agenda. Using PPM as a way of strengthen the profile of pro-poor approaches and health systems.*