

Minutes 8th Stop TB Partnership Coordinating Board Meeting
4 May 2005 -
Addis Ababa, Ethiopia

10) Focus on Africa

Chair: We will start with a full morning dedicated to the TB epidemic in Africa. Take the opportunity to welcome WHO Regional Director.

Sambo: Thank you. TB control is close to my heart. Wish to place on record our appreciation of the Board meeting in Addis Ababa. TB is one of the most important communicable diseases with 2.4 million cases in Africa. Though Africa represents only 11% of population, it represents 27% of notified cases. In particular, TB in Africa is associated with HIV infection. Even where good DOTS care is available, the HIV/AIDS epidemic, is putting so much pressure on health services that in many places they can not cope. This in turn compromises effective treatment.

We are achieving a 73% DOTS treatment success rate. For TB, cure is the only way to save lives. Countries are being supported to delivered drugs, human resources, staff. Priority is being placed at the local level and progress is being made. There are considerable constraints – functionality of health care delivery systems are overwhelmed. Lab services not adequately equipped. HR base for health is limited. Financing is inadequate. Treatment for TB is labour intensive and lasts too long. Best drug combinations are not available to all. Poverty contributes to high mortality. TB services in particular are constrained by limited reach and weak health systems and infrastructure.

However AFRO wants to give higher priority to TB control activities. Taking advantage of new opportunities to push the health agenda forward. African heads of states are taking a stand against TB, HIV and Malaria. NEPAD drafted its health strategy with WHO collaboration. TB control a priority.

We are also working to expand partnerships for health. Last week, in Brazzaville there was a consultation with the AU, ECA and RECs to work together to support countries achieve health MDG's. Translate policies into action and get governments to earmark and allocate resources. Mainstreaming of MDGs, Global Fund, Commission for Africa. Disbursement by the Global Fund has increased the financial means available. Stop TB Partnership has supported 30 countries to access free drugs through GDF. A similar number of countries have accessed support through the Global Fund. Call on the Stop TB partnership to implement on DOTS strategy and assist countries to attain the targets. Direct international focus on a larger number of African countries. Advocate for new and appropriate technologies, the best drug combinations and minimum standard of care. In this context, I am keen to listen to your views on the road map. We expect this to be owned by African governments and partners and become the ref. guide for RM and

scale up of TB control.

Beyond the immediate needs of TB, we should include health infrastructure strengthening, lab networks, drugs and logistics management.

Members of Board, we are in the process of decentralizing WHO resources to boost capacity at country level and we will aim to support the practical implementation of this road map for TB control. This is an innovative way to reach the MDGs. Also take the opportunity to thank our partners, KNCV, IUTLD, WB, USAID, DFID, Global Fund, Damien fund etc etc. Special thanks to colleagues from HQ and the Secretariat.

WHO AFRO will work with Stop TB partnership to support global TB control.

Dye: Africa and particularly, eastern and southern Africa have been affected by HIV. In cure rates & case detection – Africa better than global average. Case detection at around 50%? But with a high default and transfer rate along with a lower than average treatment Success of 73% - incidence and death rate figures remain worrying. Global Plan total cost = US\$30 billion. About US\$ 8.4 billion for Africa. African Region – in the next 2 years will cost about US\$1 billion – are plans ambitious enough? We expect to meet the MDGs globally and in 4 regions but at this stage we may miss the mark in Africa and EE. Incidence, in fact, may be more than 1990. Death around the same as 1990. If we are unlikely to meet the MDGs with the current plan- do we need a more ambitious plan?

Small: Wow - 1 in 5 default and transfer. This is neglect not just HIV.

Castro: What are the rate limiting steps that can cut incidence? Have me measured the potential impact of new tools?

Broekmans: Clear that the problems are manifold from HIV, health systems to staffing restrictions. International agencies have to balance out the way their policies are implemented. Africa needs good programme management and better data and measurement.

Freire: Clearly important to get new tools available if we are to achieve the goals. War on TB will be won or lost in Africa. Would welcome a clearer statement on the impact of new tools in Chris's analysis.

Dye: This presentation was setting the context and scale of the epidemiological problems and limitations of the programmes. Rates can be brought about by solid DOTS programmes. Death rates could be brought down by introducing ARVs based on strong DOTS programmes. New tools likely have to have biggest impact in the next decade.

Sambo: There is a need to make the case of the economic impact of TB to decision makes. The age of patients – struck down in the productive period of their lives would justify a greater investment. Bringing together Ministers of finance, economic development and ministers of health is critical. The trickle down effect from only MOH sources can be frustrating. Any move will takes time to reach communities – and we need a strong health system that can deliver in a sustained manner – care for all.

Nkhoma: Re high default and transfer rate...causing unfavourable treatment rate in the

Region. Causes are multiple – issues of access to diagnostic and treatment services and difficulty to travel to the clinics. Could we do more community follow up?

Surveillance data is sometimes unreliable. We need to strengthen the original registering district and get the data registered and accounted for after treatment.

Bilenge: While virtually every African country now has a TB control programme, Africa is the only continent where the incidence of TB is estimated to be rising (sufficiently to cause a global increase). 2.3 million cases of TB are estimated to occur each year in Africa with some 540,000 deaths. The fight to control TB globally, and to achieve the TB focused Millennium Development Goals (MDGs), will therefore be won or lost in Africa. The main barriers to better control of this disease are the HIV epidemic and the performance to date of health systems, including TB control programmes. This background paper calls for a rapid scaling up of TB control efforts across Africa. A draft "road map" for African TB control for 2005-2007 has been developed to provide additional detail on activity areas and financing needs for the key areas outlined in this paper.

Gawanas: TB is an important issue for the African Union as it is a major cause of mortality and morbidity. AU and OAU firm supporters; clear from the Scoring African Leadership on Health joint report. Leaders of the AU will meet with Ministers of Health in October in Botswana. The AU awaits the outcome of the Board meeting to take to the Ministers of Health meeting. In Abuja meeting, Africa Heads of State and Government talked about TB, HIV and Malaria and Polio. In July in Libya they will review the MDGs with the aim of getting Africa back on track to reach the targets. Most of the TB deaths could be averted with successful implementation of DOTS. In Africa DOTS is not as strong as it could be. 15 countries are not implementing DOTS and in 14 countries DOTS only covers 10 % of the population. Drug resistance also needs also to be highlighted. The AU takes note of the causal link between TB, HIV and poverty. From my childhood in Namibia, I used to here the phrase 'white people die of cancer – black people die of TB'. Getting TB carried a stigma - of poverty. Challenges facing health services are wide ranging; particularly the fragmentation of health services. Diseases co-exist in the same person and society. Adequate health services and resources must co-exist too. Health Sector and Social Sector has not been given the attention that they deserve. AU will keep on advocating – the social sector does not just consume resources. Social sector is vital for economic growth and development – it is also a productive sector. With better integration and better access to treatment will can success. Thank you very much for your efforts. The Board intervention is timely.

Adhanom : Unless we have a strong health system: it is less likely we have a strong TB programme. Sustainability in the health system – is a bridge that starts from the household. The Health Extension package – is installing a formal health system at village level. Higher health systems and the household are linked and health information being transferred to the household. Focus more on that – community DOTS will be added to the HEP and involve the household directly. This will involve training on prevention and transfer ownership of the health service to its true owners - the communities. Integrate delivery of programmes into a package. What are the minimum requirements and have we met the basics? Focus on the primary and linking local health

centres with facilities higher up the chain. Beyond this, the health system does not have any life unless we motivate the workforce and assure accountability. Starting from the lowest to the highest level – performance management. Workforce to be recognised by what it achieves and celebrated as it becomes results oriented. Changing the system so that we believe that the link between system and community. The system as an integral part of addressing TB.

Affolder: African Commission report is preparing the ground leading up to G8 Gleneagles Summit. Clear that disease specific responses need to give way to African led health initiatives /NEPAD- AU. Coordination of partnerships and donor sustainable financing with special emphasis on the reaching the poor are major themes. 2005 is a unique opportunity. Timing of this meeting is fortunate.

Van Schooten: The social-cultural issues associated with stigma are interesting. Are we approaching the issues sensitively?

Baudouy: When there is a need to expand resources – in certain countries spending more money won't get countries to the MDGS. Paper - website of the IMF (Peter Heller) - lists all the options on creating fiscal space. If the increase in public spending increases too much it will surpass what is acceptable. In Japan, in June, there is a meeting about trying to find extra fiscal space. Ensure WB and IMF are involved either in Maputo or in the Ministers of Finance meeting.

Kaysar Ali Shah: Congratulations to Mme. Gawanas. The difficulty of the public sector level also constraints are appreciated. Treatments for TB are very long and supportive measures are required – a possible incentive system? Particularly difficult when the population is scattered – achieving total coverage is a tremendous task. Mobile dispensaries were undertaken in Pakistan and could be viable here.

Roscigno: Of course, health system strengthening is important. Technological short cuts (like the leap to mobile phone use in Africa) could be one answer.

Castro: To rely wholly on new technology though is unrealistic, what would our timetables be if it were our relatives who were sick?

Teixeira: We can not wait for the perfect health systems. Harmonisation and integration now and doing everything that is possible as well as we can NOW.

Raviglione: Agreed with Fernanda. We need more of a sense of urgency. Have to recognise that figures presented reflect the reality of what is happening. Need to act. Would the African Union agree to be co-opted onto the Board? And facilitate a future declaration that TB is an African emergency. I would request that the AU invite Members of the Board to the Heads of State meeting and/or meeting of Health ministers.

Adhanhom: Sure, there is a need to scale up with a system of urgency. But ensure we use low cost methods. Minimize the costs – focus on primary health care to support prevention. At the same time, grabbing the opportunity and working side by side with disease specific control programmes.

Gawanas: Unfortunately, there is sense of urgency in Africa for all issues. No one doubts that we are committed. A major problem is harmonization. We should not keep on reinventing the wheel –especially if it is turning. A holistic approach to the issues. The role of the AU is to provide the political leadership. Working with partnerships so AU does not need to work on the ground. Everything has got to do with national authorities. HS - we are not just talking about the infrastructure...talking about staff and rules. The one factor must be built on the other.

Chesire: Why are people still dying? TB support groups ongoing but not active, stigma, poverty, food insecurity. Costs in relation to TB treatment. Delay in seeking care by TB care suspects. Pill burden (Zimbabwe patients need 14 pills). A shortage of human resources, lack of drugs for MDR. Doctor – unaware whether something is arthritis vs. TB of the knee. Doctors of lack of knowledge. TB patients when engaged and supported can increase the effectiveness of health care, mobilise the community and provide input into policy and practice. Patient led initiatives reduce stigma. 3 Ds. Better drugs, diagnostic and dignity. Increase funding for TB support groups, ensure private sector involvement and TB/HIV collaboration. Boost patient tracking systems. Above all, sustained political commitment and funding.

Basstanie (UNAIDS): Tackle the dual epidemic in an integrated and coordinated way. TB is mostly only mentioned in a tangential way as an opportunistic infections. There is an enormous opportunity to link testing of TB in all HIV positive people and to appropriately refer. What about TB prophylaxis? Can we plan an integration of proposals submitted to Global Fund?

Baudouy: Good that overall there is more money available. But gaps in funding for National TB Programmes are worrying. Budgets show a significant decline and large gaps still exist. Are the funding gaps we propose also too small? Don't just look at gaps though also need to look at absorptive capacity? Eg. In Vietnam – low income country but government paying for the programme. WB funding in Africa for TB is very low. We have to move fast to tackle TB where we can move fast but health systems also have to be good. Governments have a choice of a set of instruments from the bank including MTEF – macro economic model. TB and poverty analysis shows that 70% of PRSPs do not include TB. So despite all our good offices, the final decision is a government decision. We state that TB results in a major economic loss (4-7%) but we need a coordinated approach to health systems. If TB is not part of central planning it will continue to miss out on central funding. Above all we need to keep an emphasis on outcomes. Happy to support an African TB Financing Summit – with Ministers of Finance.

Getahun: ROADMAP – CB - liaise with the AU to raise the profile and eventually secure an AU resolution. Attend AFRO Regional Committee. Task force for Stop TB Africa. Organize HLM and next Stop TB Partner's Forum in Africa. For countries, mainstreaming TB into the development agenda. Health systems (community involvement, quality diagnosis and treatment and local drug manufacturing) strengthening activities, TB-HIV, Stop TB Partnerships; especially with community support For international institutions etc - support GDF, continue support at national level and for HIV/AIDS. NGOS should mainstream TB activities.

Discussion:

Thomas: NEPAD is a flagship programme of the AU.

Nantulya: Where is the transformational leadership? Macro economic teams in Ministry of Finance need to know that their macroeconomic framework is hurting the health sector. Abuja target of 15 %. Currently per capita spending on health is US\$ 7. Budgets in 1980 were US\$20. At that level of expenditure we are not building a healthy population. Summits will work best if the Ministers of Finance were also participating.

Chesire: Need this partnership in Africa. We should not leave the meeting until we declare TB an emergency in Africa.

Dye: Budgeting process done in the same way - so gaps are good. Need more specificity on what health systems strengthening means before we add it into the plans and quantify the costs. There is an opportunity to build the TB planning into national plans (PRSPs). This is crucially important. But we can rework our plans and budget more ambitiously to tackle TB. Measurement and outcomes – survey platforms, data on social and cultural context – not being analysed. If we make better use of the information we will be able to react and change tack more easily.

Freire: Patient as a consumer – bears the cost of drugs has a consequences...in terms of compliance (re. Chesire presentation)? Mention the African Leadership Institute as a potential resource.

Karam Shah: Critical to attract and retain staff.

Van den Borgh: Advocating and lobbying for the Financing Summit would be worthwhile but we should consider the WHOLE of Africa priority. Commitment from WHO AFRO to roll out the Global Plan.

Chesire: Patients costs – before diagnosis - when doctors are not aware of TB they often prescribe antibiotics which patients pay for. We need to work with clinical officers to make them aware. HIV workers got bonus incentive. Possible for TB?

Summary of Discussion:

Not only a natural catastrophe of AIDs also high defaulter rate. We need to strengthen TB-HIV. TB prophylaxis – already accepted but how to implement? Health systems – why the problem? Geographical dispersion. How to deal with that – mobile clinics. Plan needs:

- 1) Technical agencies to enhance the toolkit.
- 2) TB to be declared as an emergency.
- 3) How can the tools group adapt their work?
- 4) TB HIV policy implementation.
- 5) African Financial Summit.
- 6) Constituency broadening – Stop TB Africa, AU, HLM

Billo: TB a global emergency in 1993. Road Map proposal is timely: but we as a Board need to accept the pressure and assign responsible members for taking this forward.

Stewart: Yesterday in the World Leaders strategy discussion we were lacking the big idea to take to the G8. Strong call to donor representatives – address the crisis and call on G8 countries to support an Emergency TB Financing African Summit. G8 can monitor the road map on TB. Other donors and countries take to your ministries?

Castro: Botswana; defaulters – large proportion had died. A lot had got alcohol problems.

Koek: Support Billy's G8 position. A Statement from the Board would be helpful.

Raviglione: Indeed we need to focus on Community TB care – outreach to poor families. Need a task force (of the Secretariat) to monitor the implementation of this road map and make it happen.

Sambo: Struck by the figures in relation to current trends of funding. Alarming. Need

to increase the amount of funding available to TB in the Region. Agree that declaring TB and emergency would be helpful. Invite Board members to Maputo to make an address to the ministers of health to explain the road map and relations with HIV. Road map could be a key reference document for all of us. We foresee submitting the road map to MOH for ownership by countries.

Van Schooten: support the G8 point but other countries could also express to their governments to support the Financing Summit.

Jintana: TB/HIV document need to distribute document to UNAIDS offices. We need to put much more effort Africa. Need to act now. 2 diseases one patient.

FOLLOW UP

- Call on all governments, particularly the G8 governments, to support the Emergency African TB Financing Summit and the monitoring of the Road Map - ADOPTED
- ROAD MAP - endorsed.
- Urgent Action Plan and Road Map Follow Up: Koek, Nantulya, AFRO office of WHO & Mario.
- CB to send delegation to Maputo Regional Committee.
- WHO AFRO to propose TB in Africa as a Regional Emergency: to the Regional Committee.

Additional item: Green Light Committee.

Tupasi: Role of the GLC. In 2005 there are 32 projects around the world. DOTS is prerequisite for DOTS PLUS support. 13, 943 = US\$ 115 million. But basic DOTS is not enough in certain situations – of high prevalence. Needs additional resources for the Secretariat, drugs, GLC global coordination. Need US\$60 million to 2015. Urgently needs US\$ 1.5 million to prevent the collapse of the mechanism in 2005. US\$6 million a year to tackle MDR TB.

Small: Is there a business/funding plan?

Billo: What about the merger with GDF?

Loevinsohn: Can merge but this does not mean donors to GDF will want their money to go to GLC.

Nantulya: Confusion – is the GLC setting up a procurement mechanism for second line drugs? Should GDF/GLC be setting up a parallel system?

Lambrechts: Procurement through a pooled procurement system.

Loevinsohn: I understand Global Fund is prepared to look into ways of providing support to GLC. Global Fund – approached the Gates Foundation to fill short term funding.

Koek: Important to confirm GLC is critical to the fight against MDR TB. Agree with Nils.

Billo: If the Board believes GLC is important; we need to state this and find the funding for it.

Espinal: When we proposed to the WG to merge – they were only 50% ready to merge

as there were operational issues.

Lambrechts: To be clear, financial issues are separate from the merger. If the GLC does not get the money; it will have to close.

Raviglione: Merger was tried (for six months) and failed because of operational issues. Money from Gates etc will expire in August. Money from Gates may bridge the gap until the Global Fund can come on line. The cost of implementing GLC will increase because they are doing more. Logistic arrangements and infrastructure.

Castro: What happens come August?

Nantulya: A letter from the Global Fund will be going to the Gates Foundation in the course of the week. But we need to shorten the GLC process; of getting approval – so that GLC hears about proposals and countries start preparing.

Koek: We can we advance money to WHO but need more donors to GLC.

Loevinsohn: Sub-group to form offline (Peter Small – convene a sub group off line?)

Small: Regret have to decline - may be a conflict of interest.

Castro: Child Survival and Development task force. Call back Margaret Macintyre.

Van Schooten: RM mobilize strategies for MDR in affected countries. Liaison with ministry.

Roscigno: MDGS will not be reached in EE because of MDR TB – this should be part of our European strategy.

Loevinsohn: In view of decline by Small, Ex. Committee to address before the next Board meeting. Appreciate the staff of the GLC and hard work in view of stress and increased workload.

11) Global Plan to Stop TB 2006-2015

Roscigno: Global Plan – Working Groups developing a strategic plan. Steering Committee to guide the process; yesterday reviewed the development of the strategic plan and established a small writing group. The work will lead to WG and Sec. Plan with estimated costs. The impact of new tools to be done on Regional basis and added to the plan.

We expect the following plan products: a comprehensive plan, stand alone Executive Summary and advocacy products derived from the plan for specific target audiences (including a web based presentation/interactive format).

- By the end of May WG plans and regional scenarios need to be provided.
- June and July drafting of the first full global plan.
- Aug-Sept wide consultation and review. End Sept - finalised plan.
- Estimated to be launched in Davos.

Globally we will meet the global targets and MDGS except in Africa and EE. In Africa, epidemiological challenges have resulted in a huge increase in case load; inadequacy of current tools; lack of human resources and infrastructure. Largely related to macro economic issues. EE also a major concern for the MDGs.

In the plan we are moving form HBC to HB regions. One question for the Board to

answer is how do we prioritise Africa/EE and go beyond the 22 HBCs?

In Summary the Plan needs to :

- Reflect Global Strategy to Stop TB
- Discuss the Davos Launch
- Plan harmonisation with other global health agencies and strategies
- Participate in health systems community
- Measure the macroeconomic return on TB control
- Engage in the debate on the wider macroeconomic barriers to progress in Africa.

Raviglione: Request the Chair to consider a special Eastern European session in a Board in the Future. Keep the 22 country focus but build on it.

Baudouy: We can not be seen to be leaving the poor behind. Focus on high burden countries but supplement with focus on Africa. EE would confess to know less about.

Castro: Special efforts in both areas in addition to HBC.

Broekmans: Amazing that we can make the MDGS!

Van Schooten: Don't just add to the previous numbers – don't do the same thing over and over.

Freire: Should not have a plan just because of the MDGS? We should have a plan because we have a problem to solve!

Pasakorn: Should be an advocacy document but also be useful to countries.

Billo: Keep the concept of high burden countries – should not let countries off the hook (eg. Peru)

Nantulya: Layout: title, vision, mission, discuss the scenario, implementation of GP 1, what were successes and what were the problems and lessons learned, flesh out the key issues, strategies, measurement the performance of the partnership. Rolling out the plan, resource estimates. Vinand offers to join the group.

Koek: To achieve the MDGs, can we physical do the work of a country by country approach?.

Castro: Include an analysis of the Established Market Economies.

Billo: Need extra support for Chris Dye's team at HQ and regional level.

Karam Shah: Keep 22 and add a regional focus.

Van Schooten: Consultation necessary – with countries.

Maher: Aug-Sept review and comment. Global plan goes down to Regional level.

DOTS expansion WG consults with countries.

Loevinsohn: Davos launch a tactical issue - leave it to the group.

Natulya: Tim Evans – health systems – meeting of the big five donors to look at what they are going to do to support.

Raviglione: WHA resolution will call on all countries to produce a plan.

Blanc: CCM – supporting the plan. GP2 will be more complex – activities added and tied in with country health plan.

Summary

- Timetable is approved in principle.
- Ensure consultation.
- Very strong agreement on HSS outreach.

- Pay the WB for macroeconomic study – Secretariat budgeting? World Bank to provide proposal

Stewart: Ensure numbers are finalised for Global Fund replenishment.

Summary

- i) The Global Plan should provide the basis for meeting the 2015 targets in all epidemiological regions, including Africa and Eastern Europe. WG plans and regional scenarios should be revised to secure this aim.
- ii) The Partnership should retain its strategic focus on high burden countries (HBCs), and additionally focus on Africa. Given resource limitations, the DOTS Expansion WG should as a matter of urgency develop a prioritised list of countries for special efforts from the Partnership in addition to the HBCs. New, tailored approaches would be required, within the overarching "Global Strategy to Stop TB".
- iii) In addition, the Partnership should develop an integrated plan to achieve the 2015 targets in the Eastern Europe epidemiological region.
- iv) An analytical scenario should be provided for the established market economies epidemiological region.
- v) The Plan should be launched during the Annual Meeting of the World Economic Forum at Davos in January 2006. The Board gave the Steering Committee delegated authority to determine alternative arrangements for the launch date and arrangements if necessary.
- vi) An urgent analysis of the macroeconomic return on investment in TB control should inform the Global Plan. Jacques Baudouy advised that the World Bank was willing to organise this work, but that funding for consultancy was needed. The Bank would put a proposal to the Executive Secretary for his consideration.
- vii) The Board approved the Steering Committee's recommendation for immediate Partnership engagement with the health systems community to link with broader work on health systems strengthening.
- viii) The Board also endorsed the Steering Committee's recommendation that the Board should engage with the key range of players (including the AU, IMF and World Bank, WHO, the GFATM, the AIDS and malaria communities) to tackle the wider macroeconomic barriers to progress, especially in Africa.
- ix) The Board agreed that the Stop TB Partnership should work with other global health partnerships/agencies to advance harmonisation and alignment.

12) Global Drug Facility

Van Schooten: Health systems don't mean anything without drugs. GDF has 3 service lines – proposals being developed for 2 additional services lines. Achievements – 4.4 million patients.

This year though there has been an increase in the price of drugs relating to raw material prices. Demand for drugs has surpassed supply of raw materials.

Supply: Diagnostic Kits – pilot studies to be fed back to the Board in November.

Pre-qualification: phased approach to pre-qualification.

Still have the problem of longer lead times for larger orders but in order to overcome this we split larger orders.

TB drug tender 2005 will stabilise the supply of high quality drugs to countries as it increases the number of suppliers. In 2005 we will also see the development of a buffer stock.

Direct procurement process: Indonesia, Bangladesh and Mongolia – using GF funds.

Global Fund engagement needs to be increased.

TA service line to be developed – strategy paper to be presented to the Board in November.

Information and knowledge management system to be demonstrated in November.

Staff recruitment complete by September.

GDF new marketing strategy for GDF projects.

Phase out or sustaining the gains strategy, tracking system – web based to be introduced.

ISO Certification – to secure quality assessments.

Action steps towards ISO certification that will take a 7-9 month period. Estimated cost is US\$ 40,000 –US\$50 000.

Freire: Congratulations. But need to reconcile the numbers as her staff see costs going down - will work with GDF to reconcile.

Billo: Congratulations also. Can GDF should supply 100mg INH – for children? Warn that GDF should not become a substitute for provision of TA by partners. GDF should not, with its marketing, allow countries to not buy their own drugs – domestic resources should be used wherever possible.

Karam Shah: Congratulations. Would request that GDF get involved in supporting local drug manufacturing.

Koek: What is happening with the appointment of the manager position? What is being done by GDF to ensure quality if products are not pre-qualified?

Rosicigno: Strongly support the process of assuring quality through ISO certification.

Will GDF move into diagnostics? Agree GDF should not suppress local manufacturing.

Road map has also a component of supporting local manufacturing. Raw materials supply – clarify on whether we buy materials or not. Explanation of increasing price - when GDF was launched the price dropped immediately because of oversupply – supply and demand economics.

Espinal: TA to provide support to local manufacturers should be Essential Drug programme at WHO should do this. Manager position to be announced in a month.

Diagnostics kits – GDF will report back on the pilot projects in November

Matiru: Re. the cost of materials – GDF was one of the first and best examples of a pool market. US\$ 16 is still affordable. Needs greater capacity for raw materials.

Paediatrics were included in the last tender - nothing came up that was of sufficiently high quality. Will take paediatric products whenever they are available and even hold an ad-hoc tender. Engagement of partners technical missions – GDF undertakes 60 missions a year and tries to tie in with partners where ever possible. Local

manufacturers – GDF has a limited role but have tried to catalyse the pre-qualification

process. Pre-qualification - GDF tries to support the process: current products are assessed by WHO and a product document is produced supported by quality control of each batch.

- Drugs WG, GLC and GDF to meet with WHO off line to discuss support to the manufacturing/pre-qualification process.
- Instruction to GDF to work on the pre-qualification issues.
- ENDORES the ISO certification process.

13) Fidelis

Billo: Fidelis supports local initiatives to Stop TB with a case finding/detection focus. Proposals of one year duration (in the order of US\$150-250K). Focus should be on populations with limited access and 32 projects have been approved through 4 web based calls for proposals. 99 applications. With only between a 33 and 44 day delay for approval. 2 months of contract negotiations and funds flowed within 2 weeks after negotiations. Proposals are for projects costing less than 80 dollars per case and access. Project specific results. Mixed results – some v. good. Some less so but results are over a short time frame – over time results may improve. Fidelis received additional CIDA funding of CAD 8 million moving toward sustainability. There is an independent review of the projects with the aim of documenting successful and unsuccessful projects. In the future, this may be interesting for the Global Fund? Use Fidelis as a way of piloting projects prior to going to the Global Fund or World Bank for scale up.

Karam Shah: Fidelis projects have brought remarkable improvements in Pakistan. National roll out mechanism needs to be imbedded in the projects.

Xiao Donglou: Progress has been remarkable because of political commitment and an increase in the budget (more than six times) by the Government. There are more and more international cooperation projects. We have had to asked the Provinces to coordinate all of the projects and harmonise.

Koek: Is there a follow up evaluation to point out weaknesses?

Blanc: Fits well with PPM sub-group. Strong link needs to established between Fidelis and PPM Sub-Group.

Pasakorn: Do the projects impact on prevalence?

Billo: Regular evaluations during the project and an independent evaluation at the end of the project. China is a clear example of the government putting in lots of additional money and of results being more favourable in countries with strong existing programmes. Fidelis does not really measure prevalence etc just absolute numbers. US\$80 was set as a benchmark for new programmes.

14) GFATM

Spicer: There is an old Ethiopian proverb about if you put enough spider-webs together you can catch a lion. Challenge of the GF: funds available have increased by 60% since

round 1. TB proposals have been modest – 30% of all approved proposals are for TB yet overall funding for TB is 13%. Overall, GF identifies only 6% of the global resource gap for TB. Our share of the pie is going down.

Round 5 - excellent example of partnership with innovations such as the Email helpdesk and ACS Workshop in Cairo. As a partnership, we are adopting a really strategic approach to Round 5 – 31 consultants deployed to the field to support countries. Round 5 is an opportunity to show vision. Fish slide. We are emphasizing quality, scope and size of proposals. But we will also support technical assistance to respond to questions from the Technical Review Panel and support to implementation. Details of support – 58 countries (compared to 49 in round 4). 41 consultants. 24 Africa countries with a focus on Nigeria and Zimbabwe.

Blanc: We expect up to US\$ 290 million with an increased component of TB in HIV proposals. Planning TA in advance. Overcoming bottlenecks – particular management and implementation. Board is requested to support a position for Global Round 6.

Castro: Work on GF is really important. Who is sitting on TR panel with technical expertise?

Raviglione: Need to educate the TRP and others about TB. – Need a tactical approach to dealing with TRP

Carter: V. important strategic thing we are doing – strongly support – lessons learned, briefing tech review panel, more work with the Fund on the profile of TB, concerned that portfolio managers not using the fund.

Nantulya: Great presentation. Delighted with the work being done in supporting countries. Working with stop TB is a delight. Fund would like other partnerships to do the same. Round 4 was essentially focused on Malaria as they shifted to a more expensive drug regimen and AIDS moving into treatment. Now is the time for TB.

Three key issues.

- 1) Raising the profile of TB at country level. Number of partnerships at country level. Need to do more.
- 2) At the same time as we encourage countries to produce robust proposals, brief the TRP.
- 3) Pay attention now to the implementation – need strong presence on the ground.

Broekmans: Excellent news but we need to reassess the capacity of national programmes to access and utilise the funds. Only by working together will we overcome the bottlenecks.

Billo: Former TRP members not allowed to advise for 2 years after leaving. Paula - is this correct? Should beef up our support to management issues.

Nantulya: Main problems are management. Not aware about rules of membership rules. Therefore Billo to request Paula to assist.

Espinal: Congratulations to Leo's unit. One of the major problems with TB proposals is that budget and activity plans need to be consistent. National partnerships are not going to solve all the problems. Attention from the GF - invitations to Richard Feacham have been issued.

Tupasi: Absorptive capacity of countries. To imbed health systems strengthening in

each proposal or make a separate request? DOTS plus.

Castro: Borrow UNAIDs stationary - to get Feacham here! What activities for HIV/Malaria have been funded? Do we need to ask for more modern and expensive technologies?

Karam Shah: TB has a good utilization.

Nantulya: 4th component for health systems strengthening. Will deliver the message very strongly to Feacham.

Blanc: 2 TRP members changes and 2 renewed. There is a plan for briefing the TRP before they start. The briefing will use the same framework as the workshop. New technology has been included wherever it was relevant and appropriate.

Spicer: Even if this is the TB round countries can only approve what is requested.

Billo: Alex Ross preparing a backgrounder for the next replenishment conference – opportunity to work well with them on this.

Loevinsohn: what happens if good proposals are rejected because there is not enough funding. Good proposals would be first in line for round 6.

Billo: Will follow up with Paula re TRP committee.

Loevinsohn: Regarding the point for decision about support to a position: if we get an increase in round 5, we would be prepared to provide funding (CIDA).

Carter: Yes, but probably through other partners rather than this position.

Tupasi: Bottleneck is procurement. GLC can help – new manufacturers.

Loevinsohn: Summary: Pass on message to Richard. Support both decisions – if we get an increase in round 5, the partnership will try to find funding for a possible round 6 position; we will advocate with the countries for robust proposals to be submitted. Alex Ross paper – we have understated the numbers.

Raviglione: WHO will input into the paper.

Carter: Results can play the role of outside advocate.

Stewart: Pay due diligence look at the way the numbers have been calculated.

15) Kochon Foundation Stop TB Partnership Award

Raviglione: The KOCHON foundation has proposed the LEE Chong-Kun prize to be awarded to individuals or institutions for their outstanding achievements in combating the global tuberculosis (TB) epidemic. The Foundation wants to work in cooperation with WHO and Stop TB Partnership in awarding the Prize. The WHO legal department is prepared to enter into negotiations if we accept the principle of an award. Essentially the Foundation will make available US\$100 000 a year for the award. At least US\$50 000 for the prize (maybe more) and up to US\$50 000 for the expenses. This would involve every year forming a nominating committee, identifying potential candidates. WHO has requested that the DG approve the final selection of the winner – to avoid difficulties.

Chair: STOP TB Partnership Award for persons or institutions having made a huge impact in global TB - APPROVED.

16) Future Meetings Summary Sheet

Chair: Italy – 10-11th November 2005 – no comments - accepted.

Billo: Nigeria for a Board meeting- 2006 to be combined with a conference of states.

OTHER NOTES

HLM – Italy and EC at the same time; Nigeria advanced.

Van Schooten: Add MDG summit.

Koek: Health Ministers Meeting – Reg. Committee Maputo.

Van Borgh: Follow up of 2002 meeting – Brazil purpose needs more work.

Kazakhstan and Ukraine NOT getting much interest.

Freire: Total calendar of TB activities (Secretariat to complete).

Global Leaders – Review

Carter: This discussion dovetails with Road Map and EU - and is a prioritization exercise for the world leaders strategy that was discussed yesterday.

Target events – AU summit, G8, GFATM replenishment, MDG summit, WEF.

G8 – funding numbers need to be urgently reviewed. Submit language for the communiqué on closing the funding gap and monitoring the Road Map - take this forward during the meeting with PM of Ethiopia.

NGO Action Aid project – insert TB in this project if possible.

Global Plan 2 - Global Plan replenishment in June and September - estimates of donor fair shares. Need a RM plan for GP2. Media plan - coordinated effort on ML.

Production of advocacy documents and combine this with specific requests to key individuals.

Targets for World Leaders Advocacy: HBC – Africa and other priorities. 2-3 leaders, CB delegations, Economic impact of TB (World Bank Chair).

Loevinsohn: Louise to support and assist Joanne and ACSM Working Group to take the strategy forward.

Van Borgh: Need to add message linked to the event.

Baudouy: AID should be doubling in the next couple of years. Decision will be made after July when some sort of consensus will emerge hopefully linking even more strongly health to development. Will have to make an adjustment to the strategy after then. We will need to be agile but market our cause. Don't be arrogant but say what you need.

Freire: Certainly need clarity on the Global Plan funding message with a focus on Africa and TB-HIV. Time Magazine – combining message with opportunity.

International Standards of Care

Raviglione: Different language and approach to the normal public health approach –

especially to reach beyond traditional public sector health providers. Second draft of ISTC included in your folder. Request the Board to endorse the concept of int. standards, provide input on process etc. Diagnosis, Treatment etc. There will be a big document but backed up by a brief 19-20 commandments - for international TB care.

Van Schooten: Is this only to promote private sector involvement?

Castro: The history of this concept is routed in the US – where the lesson is that the private sector needs to see this as their own.

Raviglione: This is the same principle as DOTS but presenting it in different language. The aim is to get 200 societies etc. to buy into this and get them to accept this as their own.

Jintana: Does the title have to be this?

Chair: Endorse the process for consultation and request that the final version is presented to the Board for comment and endorsement.

Close

Chair: Thanks for productive meeting and to Marcos and his team for their hard work.