**Report on Stop TB Partnership Planning Workshop for the Global Plan to Stop TB (2006-2015), Montreux, Switzerland, 28 February - 4 March 2005**

## 1. Background and aims of the planning workshop

### Background: the Global Plan to Stop TB (2005-2016)

1.1 The Stop TB Partnership secretariat is coordinating the development of the second Global Plan to Stop TB (2006-2015), under the guidance of a Steering Committee[1]. The Plan provides a roadmap for TB control (implementation of interventions and the development of new tools) over the decade 2006-2015, in working towards the goal to eliminate TB as a global public health problem by 2050. The Plan will set out the actions needed to reach the 2015 global targets for TB control, which are part of the United Nations (UN) Millennium Development Goals (MDGs). The five MDG targets directly relevant to TB control are: by 2005, to detect at least 70% of new smear-positive cases and to treat successfully at least 85% of these cases; by 2015, to have halted and begun to reverse incidence; between 1990 and 2015, to halve TB prevalence and death rates. Sound planning based on rigorous epidemiological analysis and robust budget justifications will provide a powerful argument for resource mobilisation.

1.2 Development of the Global Plan started in May 2004 with building consensus in the Partnership on the Plan's purpose and outline. At its meeting in Beijing in October 2004, the Partnership Coordinating Board requested each of the Partnership's seven Working Groups (WGs)[2] to develop its own strategic plan (2006-2015) in contribution to the successful development and subsequent implementation of the overall Global Plan. The Board also agreed that regional and global epidemiological scenarios, with accompanying costings, should inform the WG strategic plans and the Global Plan. This planning process requires close interaction between the representatives of the WGs and the team assessing the epidemiological impact and costs of currently available and new tools (i.e. new diagnostics, drugs and vaccines) coordinated by WHO's Stop TB Department (Monitoring and Evaluation).

### Aim of planning workshop, 28 February - 4 March 2005

[1] The members of the Steering Group for the 2006-2015 Global Plan are: Edugie Abebe (Nigeria), Olusoji Adeyi (World Bank), Faruque Ahmed (Bangladesh Rural Advancement Committee), Nils Billo (IUATLD), Jaap Broekmans (KNCV), Ken Castro (CDC), Marcos Espinal (Stop TB Partnership), Maria Freire (Global Alliance for TB Drug Development), Philip Hopewell (San Francisco General Hospital, USA), Irene Koek (USAID), PR Narayanan (TB Research Centre, Chennai, India), Francis Omaswa (Ministry of Health, Uganda), Mario Raviglione (WHO Stop TB Department), Karam Shah (National TB Programme, Pakistan) and Roberto Tapia, (Ministry of Health, Mexico).

[2] The Stop TB Partnership has seven Working Groups: DOTS Expansion, DOTS-Plus, TB/HIV, Vaccines, Diagnostics, and new drugs, and Advocacy, Communications and Social Mobilisation.

1.3 The planning workshop in Montreux, Switzerland, from 28 February - 4 March 2005, brought together WG focal points (identified by each WG's chairperson and secretary) and the team assessing epidemiological impact and costs. The aim was to model the collective impact of proposed WG activities, assess whether the impact would be sufficient to meet the global TB targets for 2015, and estimate the costs involved. Participants collaborated in developing regional scenarios for the integrated contribution of all the WGs' activities to reaching the targets in 2015 and beyond. In addition, representatives of the WGs on new tools developed scenarios that modelled the expected impact and costs of research and development (R & D).

1.4 A list of participants is attached at Annex 1 and the agenda at Annex 2.

**2. Workshop process**

2.1 After an introduction to the workshop's objectives, each WG presented a summary of its preliminary work, based on a template (Annex 3) circulated in advance. Participants then considered the analytical framework for estimating the epidemiological impact and costs of activities. The TB Monitoring and Evaluation team in WHO's Stop TB Department has developed an Excel model with which to synthesize and analyze the inputs from the WGs and the likely impact of each contribution. The data that are needed are first of all the cost estimates for each of the activities and second the likely impact that each activity will have on indicators such as case detection and cure rates. These data are then linked to a dynamic model that can be used both to forecast the likely future course of the TB epidemic and also to determine the costs and cost-effectiveness of the interventions.

Participants discussed several issues including the following:

- the structure of the model;
- the activities and interventions expected to have an epidemiological impact, agreeing how to represent them in the model's Excel spreadsheet, and developing epidemiological scenarios based on the expected impact;
- the costing of activities and interventions expected to have an epidemiological impact, agreeing how to represent them in the model's Excel spreadsheet, and developing costing scenarios.

The final outcome, when completed, will be an overview of benefits and costs of planned activities for global TB control in the period 2006-2015.

2.2 Participants noted the need to work towards the longer-term target of eliminating TB as a global public health problem by 2050, in which the successive introduction of new tools would play a progressively more important part, particularly after 2015. For example, the impact of vaccines on TB prevalence and death by 2015 would be limited to improvements in the BCG vaccine, but the goal was licensure of a safe and effective new vaccine by 2015 with 80% coverage by 2020. Similarly, only one new drug (moxifloxacin) is likely to be introduced by 2015, yielding the prospect of shortening drug treatment from 6 months to 3-4 months. However, the longer term goal is the introduction of new drugs that would shorten and simplify treatment regimens, e.g. a 2-3 months' regimen with once weekly treatment. The timescales for

the introduction of new diagnostics are likely to be more immediate, but even so, scaling up of crucial "point of care" diagnostics could come late in the period, and go beyond it in relation to diagnosing latent TB. There was agreement that advocacy for funding and support in the 2006-2015 period depends on the Global Plan capturing a vision of the potential contribution of the new tools beyond 2015.

2.3 Participants agreed that the Global Plan 2006-2015 should comprise two interdependent and consistent sets of plans:

i) integrated regional scenarios representing the activities necessary to attain the 2015 global targets (including the use of the new tools likely to be available by 2015), with scenarios for the impact and costs of R & D for new tools up to and beyond 2015;

ii) WG (and Secretariat) strategic plans indicating how the Stop TB Partnership will ensure the implementation of the proposed activities.

There are nine TB epidemiogically distinct regions of the world: Africa (low HIV), Africa (high HIV), Central Europe, Eastern Mediterranean, Eastern Europe, Latin America, South-East Asia, Western Pacific, and the established market economies.[3] Participants suggested that while there was no funding gap for TB control in the established market economies, it could nonetheless be helpful for advocacy purposes to produce costing estimates for this region.

2.4 Developing the scenarios built on preliminary work before the workshop and on the results of various modelling studies already undertaken by some WGs. The scenarios will inform the development of the WGs' strategic plans.

2.5 The main activity of the workshop was the preliminary development of a single "optimistic yet realistic" regional scenario for each of Africa (high HIV), Eastern Europe and South-East Asia regions, plus initial work on other regions. This involved an integrated approach, with representatives of all WGs contributing to the forecast of activities, cost and impact in a given region. The progress made in developing the three initial scenarios will enable rapid progress in finalising all the regional scenarios soon after the workshop. The development of the scenario for South-East Asia provides an example of the overall process of describing the activities and funding necessary to achieve the TB control target for 2015 in that region.

2.6 Further scenarios will be developed in future representing more and less optimistic scenarios than those initially developed in the workshop.

2.7 The cost analysis was designed to make sense in planning terms, use available unit cost data and match epidemiological and demographic data included in the model. Provisional total costs of TB control from 2006-2015 were estimated for 3 regions and global R&D for new vaccines.

2.8 Representatives of the WG on advocacy, communications and social mobilisation (ACSM) presented the key elements of its draft WG strategic plan which recommends incorporation of ACSM activities by national TB programmes (NTPs). Among other points, it cited a meta-analysis of 70 ACSM evaluations which suggested that

[3] Epidemiological regions as used in *Global Tuberculosis Control: surveillance, planning and finance. WHO Report 2005.* Geneva, World Health Organization (WHO/HTM/TB/2005.349)

strategic communications in other health areas could potentially have an effect of 9-10 percentage points improvement in the desired health behaviour (e.g. for TB, 10% more people demanding sputum tests or 10% more patients completing treatment). On that basis, the WG proposed to gather evidence of the contribution of strategic communications to TB control from at least 5 HBCs by 2008, followed as appropriate by a progressive scaling up of national capacity to implement strategic communication. The WG's working assumption, based on evidence from other programmes, was that over a 10 year period at least 5% of the NTP budget should be devoted to strategic communications in "less complex" environments, and up to 15% in complex environments (e.g. high HIV countries). It noted that the GFATM encouraged applications with a strategic communications element.

2.9 In plenary on the final day, the Implementation WGs (DOTS Expansion, DOTS-Plus, TB/HIV) reported on progress in developing the regional scenarios for TB control, the WGs on new tools (vaccines, diagnostics, and drugs) reported on progress in developing their R & D scenarios, and all the WGs outlined the proposed next steps in developing their strategic plans.

## 3. Regional scenario issues

3.1 The following points were made in the course of discussion of the regional scenarios:

- Participants should work on the basis of broad assumptions which could be tested.
- Although some regions may struggle to achieve the targets, other regions may realistically be able to aim to exceed current targets (i.e. at least 70% case detection rate and 85% treatment success rate by 2005, and halving TB prevalence and deaths by 2015 in comparison with a 1990 baseline).
- The WGs on new tools should cost the development of new tools up to and including demonstration projects, but thereafter implementation costs should be included in the budgets of the implementation WGs.
- Epidemiological projections for HIV from UNAIDS/WHO are necessary to inform the modelling of projections for HIV-related TB.
- Unit costs should be calculated on a regional basis that reflects costs in the dominant countries in the region. For this exercise, they should be based on a provider cost perspective since there was no intention to raise financial resources to cover patient/household expenditures, unless subsidy of patient/household costs (e.g. food incentives and travel vouchers) was thought necessary to achieve TB control targets.
- The collaborative approach across WGs will help avoid overlap and double-counting of costs, (e.g. for unified training across DOTS Expansion and TB/HIV, or some health system strengthening activities).
- There was agreement that the Global Plan should include systematic monitoring and evaluation and operational research. The case of Viet Nam pointed up the need. Although there was agreement that certain activities (e.g. resource tracking and WG activities such as meetings) should be included in WG plans and budgets and not reflected in regional scenarios costs, the question whether activities such as technical assistance and operational research should appear as part of the regional plans or the WG plans needs further discussion.
- The WG strategic plans should specifically identify the critical small costs that, if unfunded, could compromise success.

- Further discussion is required on the allocation of costs to TB control programmes where health systems are insufficiently strong or, for example, where HIV programme are not well-established.

**4. Working Group and Secretariat strategic plans**

4.1 In October 2004, the Coordinating Board asked each WG (plus the Partnership Secretariat) to provide by the end of April 2005 its draft strategic plan of activities and budgets necessary to contribute to achieving the 2015 global TB control targets. The Board stressed that the process for developing these plans should be inclusive, to secure the necessary engagement of key stakeholders and ensure effective implementation. Each WG is likely to benefit from developing such a plan in relation to both the process and the product.

**Process benefits:**
• engages stakeholders
• clarifies activities in line with strategic direction
• aids prioritisation
• identifies resource needs
**Product benefits:**
• provides a roadmap (activities, targets, timelines)
• enables monitoring of progress towards goal
• helps resource mobilisation.

4.2 Participants made a commitment to meeting the end of April 2005 deadline for developing draft strategic plans and agreed on a broad template (Annex 3). Each WG's strategic plan should set out its vision of its contribution to reaching the 2015 global TB targets, and standard planning elements (objectives, targets, indicators, activities, timelines, milestones, budget and monitoring and evaluation). The respective Chair and Secretary will present each WG's draft strategic plan to the Global Plan Steering Committee at its meeting in Addis Ababa, Ethiopia, on 2 May 2005.

**5. The overall Global Plan**

**Global Plan format**

5.1 The work currently in hand on regional scenarios and WG plans provides a sound technical and planning foundation for the Global Plan. The participants agreed on the likely key elements of the Global Plan, as set out in 5.5 below. The final format of the Plan and any related product(s) will be decided by the Stop TB Partnership Partnership Coordinating Board at its meeting in Addis Ababa, 3-4 May 2005.

5.2 The complete Global Plan (including the regional scenarios and WG and Secretariat strategic plans) will provide the basis for the development of advocacy and communication materials that should target specific audiences.

5.3 A suggestion was made that a 2-page "flier" may be useful in early May 2005 to feed into discussions regarding GFATM replenishment, the Commission on Africa, and the UK-hosted G8 meeting (6-8 July 2005). Such a flier would provide advance publicity for the Global Plan and give provisional key findings from the analytical work, including estimates of total costs to meet the 2015 targets. Consultation with bilaterals such as DFID will establish the utility of such a document.

5.4 Participants agreed on the importance of completing the analytical work and reflect on the findings, before fully framing the main messages likely to emerge from the Global Plan. Some messages had already been identified (e.g. the international standard of TB care for all), but others had not yet been developed (e.g. the total

estimated cost of meeting the MDG targets at regional and global levels), and some possible messages were only beginning to emerge from the workshop's preliminary work (e.g. painting an integrated vision beyond 2015 with the implementation of further new tools; and the comparison of estimated costs for vaccine development and those for TB control in Eastern Europe from 2006-2015).

5.5 Participants agreed on the key elements of the Global Plan shown in the box.

**LIKELY KEY ELEMENTS IN GLOBAL PLAN TO STOP TB 2006-2015**

**Executive Summary**

**Part 1. Vision**:

- the challenge now, 2015 and beyond to 2050
- brief overview of Partnership; links with other initiatives, e.g. GFATM
- approaches, current tools & new tools (R&D/implementation synergies)
- progress against Global Plan 2001-2005
- Partnership goal, mission, objectives and targets for 2006-15

**Part 2. Achieving the targets for 2015**

- Global and regional scenarios/plans, with estimated costs; R&D scenarios; key strategic messages

**Part 3. Partnership action to achieve the goal**

- Working Group and Secretariat strategic plans, with estimated costs

**Part 4. Monitoring and evaluation**

**General points on the Global Plan**

5.6 Partnership objectives for 2006-2015

The Partnership's objectives from Global Plan 2001-2005[4] should be reviewed and, if necessary, updated for Global Plan 2006-2015.

5.7 Strategic focus

It will be important for the Global Plan 2006-2015 to define the strategic focus for its activities, in the light of current and forecast circumstances. The first Global Plan (2000-2005) took the 22 high burden countries as its strategic focus. The report of the Millennium Project Working Group on TB targeted the 22 HBCs, sub-Saharan Africa and poor people.

5.8 Poverty

[4] The objectives for Global Plan 2001-2005 are:

- To **expand** our current strategy – DOTS – so that all people with TB have access to effective diagnosis and treatment.
- To **adapt** this strategy to meet the emerging challenges of HIV and TB drug resistance.
- To **improve** existing tools by developing new diagnostics, new drugs and a new vaccine.
- To **strengthen** the Global Partnership to Stop TB so that proven TB-control strategies are effectively applied.

The Global Plan should cover a range of poverty-related issues, including the inter-relationship between socio-economic circumstances and TB incidence, and the socio-economic impact of TB and of TB control. In the light of the New Delhi Pledge and some donors' prioritization of the most poor and vulnerable people, the Plan should make explicit (a) the Partnership's policy in relation to poor and marginalized people; and (b), if appropriate in the light of the policy, strategic targets/planned activities/indicators. This work should be taken forward by the DEWG's TB and Poverty Core Group in consultation with WGs, and included in the strategic plans of the implementation WGs.

5.9 Health systems

The Global Plan will need to reflect critical health systems issues, covering both TB control's reliance on existing health systems and its actual and potential contribution to health system strengthening. For example, strengthening of laboratories would be a fundamental platform for achieving the 2015 targets. These issues would need to be considered in the context of capacity constraints at country level, and overload in some countries from multiple global health initiatives. The Partnership Secretariat is to explore the scope for a session on health systems issues at the Coordinating Board meeting in Addis Ababa, 3-4 May 2005.

## 6. Next Steps

### Action to end of April 2005

6.1 At the suggestion of the Chairman and as agreed by the participants, each WG will provide to the Global Plan secretariat a 1-page note setting out WG action until completion of the draft WG strategic plan and regional and R&D scenarios by end April 2005.

6.2 Each WG to develop its strategic plan based on extensive consultation with the WG as a whole, other key stakeholders (e.g. HIV/AIDS and health systems constituencies), regions and countries.

6.3 Each WG to refine data and continue close collaboration across the WGs and their subgroups and with the modelling team in order to complete the work to produce regional scenarios for the epidemiological regions. The two processes (for developing the WG plans and the regional and R&D scenarios) should be interactive and mutually supportive. There was consensus among workshop participants that this integrated approach to Partnership planning and working was a significant step forward with potential to yield considerable benefits.

### Timetable for action from end April 2005

6.4 The meeting endorsed the deadline of end of April 2005 for delivery of draft WG strategic plans 2006-2015 and of the global, regional and R&D scenarios. There was agreement to review the need for a further meeting involving all WGs, the Secretariat and the modelling team, after the Steering Committee and Coordinating Board

meetings (2-4 May). One possible date might be after the WHO Strategic and Technical Advisory Group and Regional Advisers meetings (20-24 June). The Partnership Executive Secretary offered support for a meeting, if one were required.

6.5 It was agreed that the handling of the interface between the launch of (a) the Global Plan and (b) "DOTS 2" (the concept of an updated international strategy to stop TB), should ensure that both content and presentation were seamless. This might have implications for the timing of the launch of the Global Plan.

6.6 The box shows the timetable for action to the end of April 2005.

| **Timetable for action to end April 2005** | |
|---|---|
| **Date** | **Milestone** |
| **end April 2005** | i) Completion of draft strategic plan 2006-2015 by each WG<br>ii) Completion of analytical work in developing regional scenarios and R&D scenarios |
| **2 May 2005** | i) Presentation of each WG draft strategic plan to Steering Committee by WG Chair and Secretary, Addis Ababa<br>ii) Presentation of regional scenarios to Steering Committee by WG representatives |
| **4 May 2005** | Coordinating Board consideration of Global Plan format and main points from scenarios/plans |
| *w/c 20 June 2005* | *Possible WG/Secretariat/ epidemiological team meeting (to be confirmed after May Steering Committee and Board meetings)* |
| **end June 2005** | Completion of draft Global Plan, incorporating WG strategic plans and regional scenarios |
| **July-August 2005** | Wide consultation and review of draft Global Plan |
| **end August 2005** | Finalisation of Global Plan after review |
| **October 2005** | Provisional timing of publication and launch of Global Plan. |

**Annexes**

Annex 1: Workshop agenda
Annex 2: Planning Workshop Participants
Annex 3: Template for Stop TB Partnership Working Group and Secretariat strategic plans

**ANNEX 1**

**Planning workshop for the Global Plan to Stop TB (2006-15)**
**Montreux, Switzerland, 28 February - 4 March 2005**

**List of Participants**

**Convenors**: D Maher and C Dye
**Chairperso**ns: G Roscigno, P Sommerfeld and K Shah
**Rapporteur**: K Caines

**Chairperson/Working Group on New Diagnostics**

Dr Giorgio Roscigno
FIND
71 Avenue Louis-Casaï
1216 Cointrin, Genève
Switzerland
Tel: + 41 (22) 710 05 90
Fax: + 41 (22) 710 05 99
Email: giorgio.roscigno@finddiagnostics.org

**Chairperson/Working Group on DOTS Expansion**

Dr Karam Shah
NTP Manager
National TB Control Program
Ministry of Health
Federal Government
Government TB Centre
Asghar Mall Road
Rawalpandi, Pakistan
Tel: + 42 41 4411709
Email: tbc@comsatns.net.pk

**Rapporteur**

Ms Karen Caines
Mill Farm, Church Road,
Brasted, KENT TN16 1HZ
UK
Tel : +44 1959 564478
Email: karen.caines@btopenworld.com

**Representatives of Stop TB Partnership Working Groups**

**Working Group on TB/HIV**

Dr Annelies Van Rie
Assistant Professor
The University of North Carolina at Chapel Hill
Department of Epidemiology
210 H McGavran-Greenberg Hall
CB# 7435c
Chapel Hill, NC 27599-7435
USA
Tel: +1 919 966 1420
Email: vanrie@email.unc

**Working Group on DOTS-Plus**

Dr Einar Heldal
Senior Medical Officer
Div. of Infectious Disease Control
Norwegian Institute of Public Health
Geitmysveien 75
PO BOX 4404 Nydalen, NO 0403
Oslo, Norway
Tel: +47 22 04 22 90/5
Mobile - +47 97517465/+47 220 425 13
Email: einar.heldal@fhi.no

**Working Group on Vaccines Development**

Dr Douglas Young
Center for Molecular Microbiology
and Infection (CMMI)
Imperial College of Science, Technology and Medicine, Flowers Building
London SW7 2AZ
United Kingdom
Tel.: +44 207 594 32011
Fax: +44 171 262 6299
E-mail: d.young@ic.ac.uk

Dr Michael Iademarco
National Center for HIV, STD and
TB Prevention
DTBE/CDC
1600 Clifton Road
Mailstop E10, Atlanta
GA 30333
USA
Email: MAI9@cdc.gov

**Working Group on TB Diagnostics**

Dr Heidi Albert
Research and Development Manager
Biotex Laboratories Ltd.
Somerset Hospital
Beach Road, Greenpoint
Cape Town, 800
South Africa
Tel: +27 (0)82 902 8199 / +27 (0) 21 425 1541
Fax: +27 (0) 21 425 9857
Email: alberth@mweb.co.za

**Working Group on TB Drugs**

Ms Gwynne Oosterbaan
Media & Communications Advisor
Global Alliance for TB Drug
Development (GATB)
59 John Street, Suite 800
10038 - New York, NY
USA
Tel: +1-212-227-7540 ext 209
Email: gwynne.oosterbaan@tballiance.org

**Working Group on Advocacy, Communication and Social Mobilization**

Dr Will Parks
Senior Adviser Public Health
And Health Promotion
JTA International
10/46 Edward Street
Brisbane, QLD 4001
Australia
Tel: + 617 3210 1652
Fax: + 617 3210 2161
Email:will.parks@jtai.com.au

Mr Paul Sommerfeld
TB Alert
22 Tiverton Road
GB-London NW10 3HL
United Kingdom
Tel: + 44 181 969 4830
Email: paul@somhealy.demon.co.uk

**Stop TB Partnership Secretariat**

Dr Marcos Espinal
Executive Secretary
Tel: +(41) 22 791 2708
Fax: +(41) 22 791 4886
Email: espinalm@who.int

Dr Dermot Maher
Medical Officer
Tel: +(41) 22 791 2655
Email: maherd@who.int

Mr Michael Luhan
Advocacy & Communications Adviser
Tel: +(41) 22 791 1379
Email: luhanm@who.int

Ms Bernadette Bourdin
Scientist
Tel: +(41) 22 791 5549
Email: bourdinb@who.int

**WHO Secretariat**

**STB**

Dr Mario Raviglione
Director
Stop TB
Tel: +(41) 22 791 2663
Email: raviglionem@who.int

**STB/TME**

Dr Chris Dye
Coordinator
Tel. +(41) 22 791 2904
Email: dyec@who.int

Dr Katherine Floyd
Scientist
Tel: +(41) 22 791 4277
Email: floydk@who.int

Ms Andrea Pantoja
Health Economist
Tel. +(41) 22 791 3225
Email: pantoja@who.int

Dr Brian Williams
Epidemiologist
Tel. +(41) 22 791 4680
Email: williamsb@who.int

**STB/THD**

Ms Eva Nathanson
Technical Officer
Tel: +(41) 22 791 1854
Email: nathansone@who.int

Dr Paul Nunn
Coordinator
Tel: + (41) 22 791 2963
Email: nunnp@who.int

Dr Alasdair Reid
Medical Officer
Tel: + (41) 22 791 4409
Email: reida@who.int

**STB/TBS**

Dr Mohamed Aziz
Medical officer
Tel: +(41) 22 791 2485
Email: azizm@who.int

Dr Leopold Blanc
Coordinator
Tel.+ (41) 22 791 4266
Email: blancl@who.int

Dr Jose Figueroa-Munoz
Medical Officer
Tel: +(41) 22 791 4629
Email: figueroamunozj@who.int

Dr Guiliano Gargioni
Medical Officer
Tel: + (41) 22 791 1518

Dr Malgosia Grzemska
Medical Officer
Tel: +(41) 22 791 3989
Email: grzemskam@who.int

Dr Knut Lonnroth
Medical Officer
Tel: +(41) 22 791 1628
Email: lonnrothk@who.int

**Other Clusters**

Dr Uli Fruth,
Secretary of Vaccines Working Group
FCH/IVB/IVR/BAC
Tel: +(41) 22 791 4395
Email: fruthu@who.int

Dr Jane Cunningham
Secretary of Diagnostics Working Group
CDS/TDR/PRD
Tel: +(41) 22 791 3587
Email: cunninghamj@who.int

**ANNEX 2**

**Agenda of planning workshop for Global Plan to Stop TB (2006-2015)**

**Monday 28 February**

**Opening session**

| | | |
|---|---|---|
| 08.30-09.00 | Registration | |
| 09.00-09.30 | Welcoming remarks | *G Roscigno* |
| | Introduction: contribution of Working Group strategic plans to the Global Plan to Stop TB | *D Maher* |
| | Review of workshop objectives and expected outcome | *C Dye* |
| | Approval of agenda | *G Roscigno* |
| | Brief review of background documentation | *B Bourdin* |

**Presentations by Working Groups of preliminary work**

Representatives of each Working Group to present a summary of preliminary work, providing answers to the questions on the template provided in advance.

| | |
|---|---|
| 09.30-10.00 | DOTS Expansion Working Group |
| 10.00-10.30 | TB/HIV Working Group |
| 10.30-11.00 | *Coffee break* |
| 11.00-11.30 | New Diagnostics Working Group |
| 11.30-12.30 | Discussion (implementation Working Groups) |
| 12.30-13.30 | *Lunch break* |
| 13.30-15.00 | DOTS-Plus Working Group<br>New Drugs Working Group<br>New Vaccines Working Group |
| 15.00-15.30 | Discussion (new tools Working Groups) |
| 15.30-16.00 | *Tea break* |
| 16.00-16.30 | Advocacy and Communications Working Group |
| 16.30-16.45 | Discussion (Advocacy and Communications Working Group) |

**Tuesday 1st March**

**Analytical framework** (for calculating epidemiological impact and costs of activities)

| | | |
|---|---|---|
| 09.00-09.30 | Introduction | *C Dye* |
| 09.30-10.30 | Explanation of framework for model (incorporating activities and projections) | *B Bourdin* |
| 10.30-11.00 | *Coffee break* | |

11.00-12.30 Worked examples of impact and costs of activities *B Bourdin*

12.30-13.30 *Lunch break*

**Epidemiological scenarios**

Break-out into each separate Working Group in order to develop and refine scenarios for evaluation of implementation of activities and epidemiological impact

13.30-15.30 Agree on the structure of the framework for the model:
a) agree on activities and interventions that are expected to have an epidemiological impact;

15.30-16.00 *Tea break*

16.00-17.30 b) agree how to represent activities and interventions on Excel spread sheets.

**Wednesday 2nd March**

Break-out into each separate Working Group in order to develop and refine scenarios for evaluation of implementation of activities and their impact (continued)

09.00-10.30 Review assumptions underpinning model; assemble and introduce these data

10.30-11.00 *Coffee break*

11.00-12.30 Develop epidemiological scenarios: expected impact of activities and interventions

12.30-13.30 *Lunch break*

**Costing scenarios**

Break-out into each separate Working Group in order to develop and refine scenarios for evaluation of costing of activities

13.30-15.30 Agree on the structure of the framework for the model:
a) agree on costing of activities and interventions that are expected to have an epidemiological impact

15.30-16.00 *Tea break*

16.00-17.30 b) agree how to represent costings on Excel spread sheets

**Thursday 3rd March**

Break-out into each separate Working Group in order to develop and refine scenarios for evaluation of costings (continued)

| | |
|---|---|
| 09.00-10.30 | Review assumptions underpinning model; assemble and introduce costing data |
| 10-30-11.00 | *Coffee break* |
| 11.00-12.30 | Develop costing scenarios |
| 12.30-13.30 | *Lunch break* |

**Prepare final presentations**

Break-out into each separate Working Group in order to prepare presentations on Friday 4 March

| | |
|---|---|
| 13.30-15.30 | Prepare presentations |
| 15.30-16.00 | *Tea break* |
| 16.00-17.30 | Prepare presentations |

**Friday 4th March**

| | | |
|---|---|---|
| 09.00 - 09.05 | Introduction | G Roscigno |
| 09.05 - 09.15 | Overview of week: TB control activities and implications for planning | C Dye |
| 09.15 - 10.15 | Implementation WGs: overview | *L Blanc* |
| | SEAR | *K Lonnroth* |
| | Eastern Europe | *E Heldal* |
| | AFR | *A Reid* |
| | Costs | *K Floyd* |
| 10.15 - 10.45 | Discussion: next steps in finalising regional scenarios | *G Roscigno* |
| 10.45 - 11.15 | *Coffee break* | |
| 11.15 - 11.30 | Diagnostics and drugs | *J Cunningham* |
| 11.30 - 11.45 | Vaccines | *U Fruth* |
| 11.45 - 12.15 | Discussion: next steps in finalising scenarios for impact of new tools | *G Roscigno* |
| 12.15 - 13.45 | *Lunch* | |

| | | |
|---|---|---|
| 13.45 - 14.00 | ACSM | *W Parks* |
| 14.00 - 14.15 | Discussion: next steps in finalising ACSM plan | *G Roscigno* |
| 14.15 - 14.30 | Global Plan: overall format; template for WG strategic plans | *K Caines* |
| 14.30 - 14.45 | Discussion | *G Roscigno* |
| 14.45 - 16.00 | Next steps: planning with WG members and regions/countries | *G Roscigno* |
| 16.00 | Meeting closes | |

**ANNEX 3**

**Proposed template for summary of each Working Group Strategic Plan**

Approx length: 5-6 pages

**1 page:** achievements against the first Global Plan (2000-2005)

**3 pages max:**
a) strategic vision (consistent with the WG's contribution to achievement of the 2015 global targets and 2050 goal)

b) objectives, targets and indicators

c) activities (including who does what), timelines and milestones

d) summary text on resource needs

e) monitoring and evaluation

f) key risk factors

**1-2 pages**: summary tabulation of activities, budget, funding and financial gap
(year by year breakdown for 2006-2010; 5-year breakdown for 2011-2015).

*Note 1: As in the GP1 Progress Report, distinguish between activity costs (e.g. research and development for new tools WGs and country needs for implementation WGs and (b) WG running costs.*

*Note 2: Funding and financing gap important for 2006-2010, but more conjectural for 2011-2015.*

| **WORKING GROUP:** *e.g. DOTS Expansion* | | | |
|---|---|---|---|
| **Activities** | **Financial needs** | | |
| | **Budget** | **Funding** | **Financial gap** |
| Objective 1<br>▪<br>▪ etc | | | |
| Objective 2<br>▪<br>▪ | | | |
| Objective 3 etc<br>▪<br>▪ | | | |
| [Total country needs] or<br>[Total research needs]<br>Total Working Group running costs | | | |
| **TOTAL 2006** *or* **2007** *or* **2008** *or* **2009** *or* **2010** *or* **2011-15** | | | |