

REPORT ON THE MEETING OF THE STEERING COMMITTEE FOR THE GLOBAL PLAN TO STOP TB (2006-2015)

Addis Ababa, 2 May 2005

INTRODUCTION

The Stop TB Partnership has asked the Partnership Secretariat to coordinate the development of the Global Plan to Stop TB (2006-2015) and has established a Steering Committee to provide guidance. At its meeting on 2 May 2005 in Addis Ababa, the Steering Committee reviewed draft Working Group (WG) strategic plans and regional scenarios; considered issues relating to the overall Plan, including the Plan's vision, timetable, and processes; and agreed the next steps in developing the Plan. The Stop TB Coordinating Board at its meeting session on 4 May 2005 noted the Steering Committee's decisions and considered its recommendations.

This report sets out:

Part 1: Summary of the proceedings and decisions of the Steering Committee, plus the decisions and comments of the Coordinating Board from its meeting session on the Global Plan (2006-2015).

Part 2: Action points, and Committee and Coordinating Board comments for finalisation of regional scenarios and WG strategic plans.

Annex 1: Meeting agenda

Annex 2: Global Plan process and timetable

Annex 3: Meeting participants.

PART 1 : SUMMARY OF STEERING COMMITTEE AND COORDINATING BOARD CONSIDERATION OF GLOBAL PLAN ISSUES (2 and 4 MAY 2005)

1. Background and meeting objectives

1.1 The new Global Plan will provide a roadmap for TB control over the decade 2006-2015, on the way towards the Partnership's goal to eliminate TB as a global public health problem by 2050. At its meeting in Beijing in October 2004, the Stop TB Partnership Coordinating Board requested each of the Partnership's seven WGs¹ 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.

1.2 The objectives of the Steering Committee meeting on 2 May were to review the development of the overall Plan, of the regional scenarios, and of each WG's strategic plan. The agenda is attached at Annex 1. A list of participants in the Steering Committee meeting on 2 May 2005 is at Annex 3.

¹ The Stop TB Partnership has seven Working Groups: DOTS Expansion, DOTS-Plus, TB/HIV, New Diagnostics, New Drugs, New Vaccines, and Advocacy, Communications and Social Mobilization.

1.3 In his welcoming remarks, Marcos Espinal, the Stop TB Partnership's Executive Secretary, emphasised the importance of a rigorous Global Plan both in providing the blueprint for meeting the 2015 global TB targets (linked to the MDGs), and in demonstrating to donors a realistic assessment of resource needs linked to outcomes. In meeting the Partnership's planning needs, the Plan will also be successfully used for advocacy.

1.4 Introductory presentations about meeting objectives, the process of developing the Global Plan, and the current position and timetable were made by Irene Koek (chairperson of Steering Committee), Dermot Maher (Global Plan coordinator) and Karen Caines (rapporteur) respectively.

2. Regional scenarios and draft Working Group strategic plans

Epidemiological regional scenarios

2.1 Chris Dye set out the global targets for TB control and reviewed progress to date. The Stop TB Partnership's global targets for 2005 are to achieve at least 70% case detection and at least 85% treatment success. The MDGs provide the overall goal "to have halted and begun to reverse the incidence" of major diseases including TB. The Partnership has adopted the global target for TB control by 2015 of halving TB prevalence and death rates (against a baseline of 1990). Countries need to reach and then sustain the global implementation targets of at least 70% case detection and 85% treatment success in order to achieve the impact target of halving TB prevalence and death rates.

2.2 In 2003 (the last year for which figures are available), the TB incidence rate was falling or stable in six out of nine epidemiologically distinct TB regions.² However, it was rising in Africa (high HIV) - though the rise in incidence was slowing - and Africa (low HIV). In Eastern Europe, the incidence rate increased during the 1990s, peaked around 2001, and has fallen since.

2.3 In 2003, the global case detection rate was 45% against the target for 2005 of at least 70%. Despite signs of acceleration in recent years (especially in some large countries such as India) the global case detection rate is likely to reach only 60% by 2005, falling short of the 70% target. Global DOTS treatment success in the 2002 cohort was 82% on average, close to the 2005 target of 85%. However, success rates in Africa and Eastern Europe were substantially lower, in part attributable to the impact of HIV and drug resistance respectively. Equally important though was the failure of DOTS programmes in these regions to monitor the outcome of treatment of all patients.³

2.4 Against this background, Chris Dye presented the impact and costing scenarios for seven out of nine TB epidemiological regions to inform the planning process. The two regions for which scenarios have not yet been produced are the established market

² The nine distinct TB epidemiological regions are Africa (High HIV), Africa (Low HIV), Central Europe, Eastern Europe, Established market economy, Eastern Mediterranean, Latin America, South East Asia and Western Pacific.

³ *Global tuberculosis control: surveillance, planning, financing. WHO report 2005.* Geneva, World Health Organization (WHO/HTM/TB/2005.349).

economies and Central Europe. These regional scenarios (developed in collaboration with the WGs) reflect the planned activities for reaching the 2015 targets, without so far taking into account the impact of introducing new tools in that period. Key elements among the planned activities included enhanced DOTS to guarantee higher case detection and cure in all regions; joint TB/HIV interventions, especially antiretroviral therapy (ART) in Africa; DOTS-Plus for multidrug-resistant TB (MDR-TB), especially in Eastern Europe; advocacy, communication, and social mobilization.

2.5 The scenarios indicated that, on the basis of current WG assumptions, the 2015 targets of halving TB prevalence and death rates are likely to be met globally and in the Eastern Mediterranean, Latin American, South-East Asian and Western Pacific regions. However, they are unlikely to be met in Africa (high HIV), Africa (low HIV) or Eastern Europe. The epidemiological challenge in these three regions is the huge increase in caseload and deaths since 1990, in conjunction with the HIV epidemic in Africa and with MDR-TB in Eastern Europe. The challenges in responding included the inadequacy of current tools and the lack of human resources and health infrastructure.

2.6 The cost of implementing these Global Plan activities in all regions except the established market economies and Central European region was estimated at approximately \$30 billion from 2006-2015. This amounts to \$2.2 – 3.4 billion per year from 2006 to 2015, compared with approximately \$2 billion in 2004-5. The extra spending was mostly for implementation of the basic DOTS strategy. Regionally, most money would be spent in Eastern Europe. Specific costs for collaborative TB/HIV activities (over and above implementation of the DOTS strategy) were relatively low and would be re-examined.

2.7 In discussion, Steering Committee comments included the following:

- The Committee endorsed the two planning dimensions for the Global Plan already being undertaken: (i) Partnership activities to achieve the goal, as defined in the WG and secretariat strategic plans, and (ii) the integration of all WG activities to produce the regional impact and cost scenarios.
- The Committee expressed support for planning on the basis of the nine epidemiologically distinct TB regions (rather than, for example, WHO's six regions).
- Scenarios of selected regions should be developed to illustrate the impact of the expected introduction of new diagnostics and shorter drug treatment before 2015. The Global Alliance for TB Drug Development has commissioned a paper on the impact of shortened drug treatment that is due to be submitted shortly to the Lancet.
- Evidence presented suggested that improvements in both case detection and treatment success were required.
- In addition to the current "optimistic yet realistic" planning assumptions, an important task for the TB/HIV WG is to describe the nature of the paradigm shift needed in order to reach the targets in Africa.
- Based largely on a detailed analysis of TB and HIV in India, there is little evidence of a rise in HIV rates in South East Asia.
- While there is currently little evidence of MDR-TB in Africa, this is likely to grow with increasing use of rifampicin. The situation should be monitored.

- There was general agreement on the need for strengthening surveillance systems, linking with the Health Metrics Network. In addition, there was debate about the desirability and practicability of prevalence studies in selected countries in each region.
- Although the debate about health system strengthening was being conducted in very generalised terms, in their plans, the WGs should define specifically both the health systems barriers and what the Stop TB Partnership can do to strengthen health systems.

Draft Working Group strategic plans

2.8 The Committee then reviewed individually the seven draft WG strategic plans, based on assumptions of feasibility unconstrained by finance. A background paper prepared for the Committee suggested areas for review based on the template agreed for the strategic plans.

2.9 Detailed comments from the Committee to guide finalisation of the WG plans and the regional scenarios are set out in Part 2 of this report below.

3. Consideration of Committee paper outlining key issues for discussion

Vision, mission, objectives, targets, principles, and values

3.1 The Global Plan 2006-2015 should begin with a succinct visionary statement that is "short, sweet and inspirational". While the detailed planning would run only to 2015, the vision should extend beyond that to encompass the 2050 target and the full contribution of new tools. The statement would be developed by the Writing Group, which may consider testing it on key audiences.

3.2 Currently the Partnership promoted on its website a mission, targets, objectives, and principles and values (quoted in the Issues paper prepared for the meeting). These should be re-examined in the light of the approach to the Global Plan, e.g. to incorporate a reference to new tools in the mission, and a reference to commitment to protecting vulnerable populations in targets and objectives. The Plan should incorporate specific and measurable approaches to meet the needs of the poor and vulnerable. In general, the Plan should articulate concretely and persuasively what the Stop TB Partnership can deliver.

3.3 The Partnership's objectives towards reaching the 2015 targets should be based on the elements of the new "Global Strategy to Stop TB", as finally approved.

Cross-cutting issues

3.4 The Steering Group identified the key cross-cutting issues as health system strengthening; TB and poverty/marginalisation; TB and children; TB and women; monitoring and evaluation. Consideration of these issues should be infused through each WG plan, with a summary passage in the main text.

3.5 Health systems barriers remain a significant constraint. In addition to the more specific delineation in individual WG plans of barriers and opportunities for strengthening health systems (see above), the Partnership should immediately engage

with activities currently being led by the health system community. As a first step, a meeting involving the Executive Secretary, the Director of the WHO Stop TB Department and one other member of the Coordinating Board should be arranged with the ADG for EIP (Tim Evans) in WHO by mid-late May.

3.6 In addition, the Steering Committee recommended that the Coordinating Board should engage with the African Union (AU), International Monetary Fund (IMF) and World Bank, WHO, the Global Fund to fight AIDS, TB and Malaria (GFATM), the AIDS and malaria communities, and other actors to tackle common health system problems and the wider macroeconomic barriers to progress in Africa (since, for example, the human resource problem is driven in part by macroeconomic factors, including salary incentive structures and emigration of trained health workers).

3.7 There is need for an authoritative analysis of the macroeconomic return on investment in TB control to convince Ministers of Finance and of Economic Development of its importance. Such an analysis has proved an effective tool for Roll Back Malaria. It is important to get specific references to TB control in national planning activities, including Poverty Reduction Strategy Papers, Mid-Term Expenditure Frameworks, and Health Sector Strategic Plans.

3.8 To relieve the transactional burden on countries, the Stop TB Partnership should work with other global health partnerships/agencies on harmonisation and alignment.

4. Processes and products

Steering Committee and Writing Group

4.1 Over the next few months, the Steering Committee will continue to provide oversight by e-mail and teleconferences. In addition, it agreed to establish a 5-person Writing Group comprising the Committee chairperson (Irene Koek), Dermot Maher, Karen Caines and two Committee members (PR Narayanan and Roberto Tapia subsequently agreed to serve on the Writing Group).

Products

4.2 The Committee agreed that there should be a number of Global Plan products:

- a) a comprehensive document (100+ pages) with regional scenarios and summaries of the WG and Secretariat strategic plans in a standard format to serve as the Partnership's own working plan;
- b) a stand-alone Executive Summary of the Global Plan for wide dissemination to a range of audiences inside and outside the TB community;
- c) advocacy and communication materials derived from the Plan when finalised for specific target audiences, e.g. a brochure no longer than 2 sides of A4 to be available when the Plan is launched;
- d) In addition to the making the Plan available as a printed document, the Secretariat should make the Global Plan and full WG plans available on the web in dynamic and innovative formats for different audiences, with links to other associated material.

4.3 The structure of the Plan should be reviewed in the light of comments.

Plan timetable and process, including consultation

4.4 The Steering Committee approved the proposed process for development of the Plan.

4.5 As with developing the WG plans, the process should be inclusive, to secure the necessary engagement of key stakeholders and ensure effective implementation. A full consultation and dissemination strategy should be developed by mid-June. The Secretariat will circulate the first draft of Plan for comments in early August. The draft will also be made available on the web for comments. Rather than stakeholder meetings at country level as once proposed, the WGs should continue to handle consultation with their members. The Secretariat should send the first draft for comments from selected individuals and organisations beyond the Partnership (Steering Committee members should send contact details of recommended individuals/organisations to Dermot Maher).

4.6 The World Economic Forum has offered an opportunity to launch the Global Plan during its Annual Meeting at Davos from 25-29 January 2006. The Committee agreed to recommend a launch at Davos to the Coordinating Board.

4.7 The Committee agreed an extension to end May 2005 of the deadline for completion of (i) the regional scenarios; (ii) all WG strategic plans. These would be circulated to the Steering Committee for final comments. Since the Secretariat plan needs to reflect the WG plans, this should be finalised by mid-June.

4.8 The table below provides a summary timetable for producing the Global Plan. A more detailed timetable is attached at Annex 2.

Global Plan to Stop TB (2006-2015): summary revised timetable	
Date	Milestone
2 May	Global Plan Steering Committee meeting
4 May	Coordinating Board consideration of Global Plan issues
end May	Finalised WG plans and regional scenarios
June-July	Drafting of first full Global Plan
Aug-September	Wide consultation and review
end September	Finalised Global Plan
Oct-December	Development of advocacy materials. Production of Global Plan (editing, design, translation, printing etc)
Late January 2006	Launch of Plan at the World Economic Forum Annual Meeting, Davos, 25-29 January 2006

4.9 The Global Plan 2006-2015 would need to be updated. Options include an update every three years, or in 2010.

5. Coordinating Board consideration of the Global Plan: 4 May 2005

5.1 The Coordinating Board of the Stop TB Partnership considered the Global Plan at a meeting session on 4 May 2005, in Addis Ababa. The Board had earlier in its meeting considered a number of relevant issues, including a proposed "Global Strategy to Stop TB" and a roadmap to intensify action to reach the targets for TB control for 2015 in Africa. It also heard presentations for information on progress and plans for new drug and new vaccine development.

Board decisions

5.2 Following a presentation of the Steering Committee's deliberations, decisions and recommendations from Dr Giorgio Roscigno, the Board endorsed the Steering Committee's decisions and recommendations. The Board's decisions were the following:

- 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 focus countries in addition to the HBCs for special efforts (including monitoring) by the Partnership. 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.

5.3 In addition, the Board made the following comments:

- i) Based on the plans presented, the forecast achievement on a global basis of the targets for 2015 would represent significant progress in TB control, and provides an important advocacy message.
- ii) The Board expressed its appreciation of the analytical work undertaken by Chris Dye and his team in conjunction with the WGs as a key contribution to the development of the Plan. This kind of analysis would be needed on a periodic basis during the life of the Plan from 2006-2015.
- iii) The GFATM Replenishment Conference in September 2006 represents a critical juncture. It is important that the estimates of resource need for the Global Plan (2006-2015) should be fully finalised in time for consideration there. The current timetable for development of the Plan meets this requirement.
- iv) The details of the proposed structure of the Plan should be reconsidered, bearing in mind lessons from the first Global Plan (2001-2005) that had a complicated structure.
- v) The Board noted that, in line with its earlier guidance, many WGs were undertaking extensive consultation with countries and other partners as part of the process of developing their strategic plans. Finalisation of plans by the end of May should continue to reflect extensive consultation. In addition to consultation through the WGs, the Secretariat will organise an extensive review process in August-September 2005.

PART 2: SUMMARY OF ACTION POINTS AND COMMENTS

6. Steering Committee action

- Steering Committee members to advise Dermot Maher of contact details of individuals/organisations beyond the Partnership to be consulted on the draft plan.
- Jacques Baudouy, World Bank, to provide the Executive Secretary with a proposal for urgent analysis of the macroeconomic return on investment in TB control to inform the Global Plan.

7. Partnership Secretariat action

- Partnership Secretariat to finalise its 2006-2015 plan by 17 June 2005.
- Dermot Maher and Karen Caines to finalise a consultation and dissemination strategy for the Plan by 17 June 2005.
- In collaboration with the Director of the WHO Stop TB Department, the Secretariat to arrange a meeting on TB control and health systems with the WHO Assistant Director-General for Evidence, Information and Policy (Tim Evans), the Partnership Executive Secretary and a member of the Coordinating Board before the end of May.

8. Comments for all Working Groups in finalising their plans

- WG plans (2006-2015) must be completed by end May 2005.
- WG Secretaries should advise Chris Dye and Dermot Maher as soon as possible of all further assistance required from Chris Dye and his team during May in order to enable him to schedule the work.

- WG plans should be revised as necessary to secure the aim of meeting the 2015 targets in all epidemiological regions, including Africa and Eastern Europe.
- In addition to the statement of the global targets for 2015 as agreed by the Partnership, the Plan should also express what achievement of these targets would mean in terms of lives saved and TB cases averted.
- As agreed at the Montreux workshop, each completed WG plan must include the WG's vision of its contribution to reaching the 2015 global targets, and the standard planning elements of objectives and targets; activities, timelines and milestones; budget, funding and financial gap; monitoring and evaluation approaches; and key risk factors. Milestones are critical to measure progress and reinforce accountability; the DOTS-Plus WG plan provides a good example of setting milestones. Plans should also set out the expected impact of activities, linked to the regional scenarios.
- Scenarios should be developed for selected regions to reflect the impact of introducing the new tools expected to become available in the period to 2015. This requires close collaboration among implementation WGs and the new tools WGs: (a) immediately, in order to identify the regions and develop these scenarios with Chris Dye; and (b) on a continuing basis to ensure a cohesive approach.
- WG plans should be as bold as possible without being unrealistic.
- The Plan should cover the key cross-cutting issues (e.g. health systems strengthening; TB and poverty; TB and special groups, e.g. the poor and marginalized, children, and women), with specific attention to these issues in the WG plans. The Plan should indicate what the Partnership can contribute concretely to strengthen health systems.
- Individual WG plans will be posted in full on the web. The hard copy document will carry 5-6 page summaries of the plans, as agreed at Montreux.

9. Comments on individual Working Group plans

9.1 DOTS Expansion Working Group (DEWG)

- Given the Coordinating Board's decision that the Partnership should retain its strategic focus on high burden countries (HBCs) and additionally focus on Africa, the DEWG should as a matter of urgency develop a prioritised list of focus countries in addition to the HBCs for special efforts (including monitoring) by the Partnership.
- The Committee noted the DEWG's intention to do further work by end May on issues related to childhood TB, and TB and poverty; the WG's broad activity areas; the epidemiological impact; and resource needs. It should also cover key risk factors.
- The DEWG should ensure a seamless strategic fit between its plan and the elements of the "Global Strategy to Stop TB", as approved in principle (subject to specific comments) by the Coordinating Board on 3 May 2005.
- The plan should seize every opportunity to accelerate progress by jumping steps in target countries, for example in relation to laboratory culture capacity.
- The DEWG should re-consider its earlier decision to package and cost together a number of interlinked elements including PAL, PPM, and Community DOTS.

- The DEWG should follow up discussions at the Montreux workshop with the new tools WGs.

9.2 DOTS-Plus Working Group

- The DOTS-Plus WG should take the lead in developing a plan (in collaboration with other WGs) to achieve the 2015 targets in the Eastern Europe epidemiological region. The vision of the DOTS-Plus WG plan should relate to saving lives and avoiding transmission of TB rather than “Drug resistance surveillance and DOTS-Plus integrated as routine components of TB control providing access to diagnosis and treatment for all TB patients and by all health care providers”. The plan should outline the strategy for the Green Light Committee (GLC).
- The WG should review their presentation statement that the combined impact of DOTS and DOTS-Plus would be a reduction in previously treated patients from 19%-15% of all confirmed TB cases.

Note

Drug costs in the draft DOTS-Plus plan are based on experience from DOTS-Plus projects. These projects were undertaken in "hot spots" and may overestimate drug costs more generally.

9.3 TB/HIV Working Group

- Work should be undertaken rapidly to specify:
 - concrete WG activities
 - timelines and milestones
 - estimated budget in relation to specific activities, and funding
 - impact.
- The WG should consider a target for saving lives (reducing the number of deaths).
- The plan’s costing covered provision of 6 months of ARVs during TB treatment. The Steering Committee noted that policy discussions were underway with the WHO HIV Department, and called for a clear strategy based on the principle that ART should not be started unless there was a commitment from an HIV/AIDS programme to maintain it after the 6-month period. The Committee noted that currently responsibility for total HIV care during TB treatment varied from place to place.
- The plan should also include the point made in relation to the DEWG plan about accelerating progress in relation to laboratory culture capacity, even if the costing is reflected only in the DEWG plan to avoid double-counting.
- The plan should incorporate the "road-map" for TB control in Africa presented to, and approved by, the Board.

Notes

1. Up to date HIV projections for the next ten years are still awaited from UNAIDS.
2. Since collaborative TB/HIV activities are supplementary and complementary to existing TB and HIV programmes, the availability and quality of the latter are major enabling or constraining factors.

9.4 New Diagnostics Working Group

- The completed plan should contain a statement of expected impact, and the estimated funding and financial gap.
- In addition to patient benefits, new diagnostics can potentially reduce the labour-intensiveness of TB programmes. Given past experience of timelags in introducing new TB control technologies, the WG should plan with the implementation WGs to ensure the introduction of new diagnostics as rapidly as possible.
- This continuing collaborative work should also consider the implications for NTP managers.

9.5 New Drugs Working Group

- The completed plan should contain a statement of expected impact, and the estimated budget, funding and financial gap.
- It was noted that the length of TB drug trials precluded introduction before 2010 of moxifloxacin and gatifloxacin to provide a shorter (2-3 month) regimen. Nonetheless, work needed to start now to create demand, and preparation of the rollout should be factored into WG plans. This would require close collaboration and planning with implementation WGs.

Notes

1. In answer to questions from the Committee, the WG advised that there are strict criteria for entry to the drug pipeline. For example, all candidates must be compatible with ART. All compounds are effective against MDR-TB.
2. Although TB treatment in children presents particular challenges, at this point the WG is not pursuing specific treatments tailored for children with TB.

9.6 New Vaccines Working Group

- The WG should liaise with the other new tools WGs and develop a strong statement about the need for investment in basic science.

Note

1. The WG advised that part of the logic for adding the new vaccine to BCG is that BCG has wider benefits, e.g. it is somewhat preventive against leprosy and there are suggestions in Africa of a wider contribution to reducing child mortality.

9.7 Advocacy, Communications and Social Mobilization Working Group

- The Committee noted that the WG intended to develop further both elements of its plan, i.e. the country level and the global advocacy elements.
- The advocacy element of the country level section should be strengthened.
- The WG may wish to consider piloting their proposal for strategic communications before rapid roll-out. If WG confirmed its plan to secure 15 HBCs implementing strategic communications by 2008, the countries should be selected in consultation with the DOTS Expansion WG to ensure an optimal strategic focus.

- The ACSM WG had debated whether there should be a global advocacy section at all, or whether each of the other WGs should contain an advocacy section. The Committee advised that a single global advocacy plan articulating resource needs would be preferable. This had formed part of the rationale for establishing the WG.

**Meeting of the Steering Committee for the Global Plan to Stop TB (2006-2015)
Addis Ababa, 2 May 2005**

AGENDA

Chairperson: Irene Koek
Rapporteur: Karen Caines

Opening session

09.00-09.15	Welcoming remarks	<i>Marcos Espinal</i>
	Review of meeting objectives and expected outcomes	<i>Irene Koek</i>
	Approval of agenda	<i>Irene Koek</i>
	Brief review of background documentation	<i>Dermot Maher</i>

Background

09.15-09.45	i) process of development of Global Plan	<i>Dermot Maher</i> <i>Karen Caines</i>
09.45-10.30	ii) scenarios to inform planning: analysis of implementation, cost and impact	<i>Chris Dye</i>

Coffee break

Presentations by representatives of all Working Groups (WG) on progress in developing strategic plans, followed by Committee discussion

	<i>Implementation WGs</i>	
11.00-11.30	DOTS Expansion WG	<i>Karam Shah</i>
11.30-12.00	DOTS-Plus WG	<i>Thelma Tupasi</i>
12.00-12.30	TB/HIV WG	<i>Jintana Ngamvithayapong-Yanai</i>

Lunch break

	<i>Research and Development WGs</i>	
14.00-14.30	Diagnostics	<i>Giorgio Roscigno</i>
14.30-15.00	Drugs	<i>Maria Freire</i>
15.00-15.30	Vaccines	<i>Douglas Young</i>

Coffee break

16.00-16.30	Advocacy, Communications and Social Mobilization WG	<i>Joanne Carter</i>
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16.30-18.00	The Global Plan: Committee paper on key issues for discussion; issues for discussion at Coordinating Board on 4 May 2005; next steps.	
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**Development of the Global Plan to Stop TB, 2006-2015
Process and revised timetable**

<i>Global Plan to Stop TB 2006-2015: Process and revised timetable</i>	
<u>Date</u>	<u>Milestone</u>
2 May 2005	Global Plan 2006-15 Steering Committee meeting, Addis Ababa i) Presentation of regional cost and impact scenarios by C. Dye ii) Presentation of each WG draft strategic plan by WG representatives iii) Consideration of next steps for WGs; Global Plan strategic issues; future process and timetable iv) Consideration of issues for endorsement by the Coordinating Board
4 May 2005	Coordinating Board consideration of Steering Committee recommendations
end May 2005	i) Circulation of finalised strategic plans 2006-2015 from each WG (7 plans) ii) Finalisation of analytical work in developing scenarios for different regions and new tools, and circulation to Steering Committee.
17 June 2005	i) Secretariat plan finalised and circulated ii) Finalisation of consultation and dissemination strategy for the Plan
June-July 2005	Drafting of full Global Plan <ul style="list-style-type: none"> ▪ June-early July: Writing Group drafts zero draft full Global Plan ▪ By 8 July: circulation of zero draft full Global Plan for Steering Committee comments ▪ By 18 July: comments received from Steering Committee, followed by revision to produce 1st full draft Global Plan
end July 2005	Finalisation of 1 st full draft Global Plan, incorporating WG strategic plans and regional scenarios
August-September 2005	Wide consultation and review of draft Global Plan <ul style="list-style-type: none"> ▪ 4 Aug: circulation of 1st draft Global Plan/web consultation ▪ end Aug: deadline for comments on 1st draft ▪ 16 September: 2nd draft circulated to Coordinating Board and Steering Committee ▪ 23 September: final comments from Coordinating Board and Steering Committee, followed by final revision of Global Plan
end September 2005	Finalisation of Global Plan after review
October- December 2005	Development of advocacy materials Production of Global Plan <ul style="list-style-type: none"> ▪ final editing of text completed ▪ layout and design completed ▪ translation of full Plan into French and Spanish, and possibly executive summary/advocacy document into other languages (eg Russian) ▪ printing completed.
Late January 2006	Publication and launch of Global Plan 2006-2015 at the Annual Meeting of the World Economic Forum at Davos, 25-29 January 2005

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