

**Stop TB Coordinating Board meeting
Cape Town, South Africa
28–29 October 2002**
Final Report (CB-STB 02-02)



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Action points

1. Four high TB burden countries (HBC) have developed plans to reach additional patients

- 1.1. The Board agreed with and endorsed the 4 HBC country plans, in support of which the Board will act as broker between countries and supporting agencies (donors, technical institutes, etc.), including the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). A plan will be developed to outline Board support to these countries (*Secretariat and DEWG by end Nov. '02*);
- 1.2. The Board will respond to countries' requests for high-level missions with the aim of: a) obtaining the highest level of political commitment to Stop TB; b) building political will within countries at State-/Congress-/National Assembly-level, where appropriate. The Secretariat will develop an operational plan for high-level missions (*Secretariat and DEWG by end November '02*);
- 1.3. The commitments made during high-level missions will be followed up by technical mission to ensure implementation of political commitments. Regular updates on planned technical monitoring missions will be sent to Board members. Mission reports and lessons learned on specific country strategies will also be made available (*DEWG and Secretariat-ongoing*);
- 1.4. The Board will invite other HBC, through a similar process to outline their constraints, potential solutions and needs for Partnership support (*Secretariat will outline a proposal by January'03*).

2. Slow increase in tuberculosis (TB) case detection requires urgent attention

- 2.1. The DOTS Expansion Working Group (DEWG) was charged with developing specific proposals for new approaches to increase case detection and notifications, involving new tools as they become available from the relevant working groups (*DEWG will prepare a series of proposals as soon as possible*);
- 2.2. Through the work of the TB and Poverty Advisory Committee, the Board requested action oriented recommendations on poverty and TB (*Secretariat and DEWG to present to the next Board meeting*).
- 2.3. The DEWG will prepare guidance for program managers on decentralization (*DEWG by end January '03*).

3. Agreement to further strengthen the relationship between Stop TB and GFATM

- 3.1. The exchange of letters between the GFATM Secretariat and the Board will form the basis for further articulation of details on the relationship between Stop TB and GFATM and development of a draft Memorandum of Understanding (MOU). This draft MOU and the draft UNAIDS MOU will be circulated to the Board (*Secretariat by 22 November'02*);
- 3.2. A response to Dr Feachem's letter will be sent when the draft MOU has been endorsed by the Board (*Secretariat by mid December'02*);

4. Endorsement of 2003 workplan and budget for the Stop TB Partnership Secretariat

- 4.1. Future plans and budget for the GDF and Partnership Secretariat will be presented separately (*Secretariat to present to the Board in Fall'03*).

5. Other issues

- 5.1. GDF evaluation. The Board agreed on the proposed process for the GDF evaluation. An adjudication committee has been formed and will meet in New York to review the GDF evaluation proposals (*Adjudication committee, 27 November'02*).
- 5.2. GLC-GDF harmonization. The Board endorsed the letter from the DOTS Plus Working Group setting out the next steps for GDF and GLC convergence.
- 5.3. Financing issues. World Bank to finalize the clearance process and initiate individual agreements with DFID, OSI and CIDA (*World Bank by 22 November*).
- 5.4. Next Stop TB Coordinating Board meeting. The Secretariat will explore opportunities for the next Board meeting to be held in the first quarter of 2003 (*Secretariat by end November'02*).

1 Opening (CB-STB 02-02-01)

The Chair introduced 3 new board members representing India, Nigeria, and the TB Vaccines Working Group. The delegations from 4 HBC countries were welcomed, together with high-level representation from USAID and UNAIDS. The Vice Chair was unable to attend and was replaced by Dr Manuel Dayrit.

Several points of progress were reported since the Osaka Board meeting.

- Increased funding for TB has been received, reducing the funding gap in the Global Plan to Stop TB.
- DOTS coverage has increased rapidly in India, the Philippines are close to reaching the TB targets, and Nepal reached targets this year.
- The GFATM Board meeting in October 2002 decided that funding for second-line TB drugs must be approved by the Green Light Committee (GLC) of the DOTS-Plus Working Group.
- A new drug compound (PA824) has been licensed by Chiron to the Global Alliance for TB drug development.
- The GDF continues to make rapid progress. Four rounds of applications have been held and 51 applications processed, of which 33 have been approved (total of 1.6 million patients). 12 countries have received drugs. The Novartis Foundation has proposed an in-kind donation of 0.5 million DOTS treatments over 5 years to the GFATM, which will be channelled through GDF.

2 Global TB situation: epidemiological analysis (CB-STB 02-02-02)

Dr Chris Dye presented the slow progress in TB case detection, which at the current pace means that the 70/85 targets will only be met by 2013. Modeling case detection rates shows that when 100% population coverage is reached, global case detection rates will only be 40-50%. Some of this slow detection rate could be related to inadequate reporting systems. New interventions are required to reach the additional cases. Public services need to expand DOTS services and the private sector should be more involved.

Discussion:

Surveillance systems and the quality of data in HBC countries must be improved. Over- or under estimations may contribute to incomplete or incorrect reporting and could cause difficulties for interpretation of data in specific countries. However, overall these statistics are appropriate for global level planning.

Action:

- 2.1 Need for better data, and continuous support to countries to improve their surveillance systems for improved monitoring of in-country DOTS expansion performance.

3 Global DOTS expansion: status, constraints and solutions (CB-STB 02-02-03)

Dr Mario Raviglione outlined the programmatic challenges for tackling the slow progress of case-detection. The outcomes of the DEWG meeting (Montreal, October) were reported. The challenges for DEWG and the Board include inadequate primary care services, and human resources, working with HIV/AIDS programmes, linking to the private sector, and lack of new tools. The proposed strategic direction for the DEWG takes two tracks: a) continue the expansion of DOTS through government services, inclusive of a clear plan for human resource capacity strengthening; b) identify new approaches targeting both government and non-government (private and civic society) systems to rapidly increase case-detection based on country specific needs.

Discussion

- 3.1 To address the constraints of low case-detection, the focus should be placed on the public health system, including its coverage and quality, so that *additional TB patients* can be absorbed by DOTS programmes. Based on the assessment of these programmes, solutions for missing or additional cases need to be found and the gaps filled. New measurements and indicators must be developed to accurately reflect progress at country level, as new partners, additional patients or "non-DOTS" patients are included in the system.
- 3.2 Board members emphasized the need for a more aggressive stance on involving *community-based groups and the broad corporate sector*. Specific TB messages need to be created for community mobilization activities (e.g. involvement of TB patients/ HIV-positive people), promoting TB in medical curricula, and targeting messages for the political arena (e.g. human resource related issues). Board members proposed that missions be organized to HBCs addressing specific and targeted topics.
- 3.3 Several Board members pointed out the importance of *reaching the poorest and adapting poverty reduction strategies* as part of the Global Plan to Stop TB. Clear impact indicators on TB and poverty need to be developed. The Board requested to discuss poverty and TB in the next meeting.

Action:

- 3.3.1 The DOTS Expansion Working Group (DEWG) was charged with developing specific proposals for new approaches to increase case detection and notifications, involving new tools as they become available from the relevant working groups (*DEWG will prepare a series of proposals as soon as possible*);
- 3.3.2 Based on discussions with HBC, plan strategic high-level missions for Board members to HBC, to address specific country obstacles (*Secretariat and DEWG*);
- 3.3.3 Through the work of the TB and Poverty Advisory Committee, the Board requested action oriented recommendations on poverty and TB (*Secretariat and DEWG to present to the next Board meeting*).

4 Update from other Stop TB working groups (CB-STB 02-02-04)

4.1 New TB diagnostics working group

New diagnostic tests are becoming available. The following five types of new diagnostic tools could radically increase the case-detection rates: 1) new sputum tests, which are dependent on the functioning of the laboratory system in countries; 2) rapid culture methods, which changes colour within 7-10 days; 3) PHAGE tests, which show results within 48 hours; 4) test based on serology, which can be done at bed-side; 5) patch tests. It is important to recognize the limitations of each technology and prepare the public health system accordingly before implementation.

4.2 Global Alliance for TB Drug development

The Alliance has three new drug candidates, and is investing in enabling new tools, including animal models studies. Ethambutol analogs are entering in Phase-II clinical trials, and Moxifloxacin clinical trials are also in Phase-II.

4.3 TB Vaccines working group

The TB Vaccines working group is facing challenges related to logistics, finances and technical research. But at the same time is progressing rapidly to the objectives they have set out. The goal of the TB Vaccine Working Group is to have a safe, effective and reasonably priced TB vaccine licensed for global distribution by 2015, and to have the vaccine widely used in TB high-burden countries by 2020. This requires advocacy from the Board to stimulate and support the study of 5-10 vaccine candidates in phase I/II trials by 2005.

4.4 DOTS Plus working group (MDRTB)

The DOTS Plus working group is making progress in the specific countries, which served as pilots, such as Peru. The fact that the Green Light Committee (GLC) is recognized as procurement mechanisms for the GFATM, demonstrates progress at the global level. Through GFATM, funds for 2nd line drugs are going to countries. Dr Jim Kim referred to the work on 'access to drugs' as part of the Millennium Project in support of the Millennium Development Goals, in which TB is now firmly established as an important area.

4.5 TB/HIV working group

The TB/HIV working group held it's 2nd meeting in June this year in South Africa. The Strategic framework has been finalized and various implementation projects are ongoing. Specifically, Protest pilot projects are running in Malawi, Zambia and South Africa. New projects will be initiated in Kenya, Ethiopia, Mozambique, Tanzania and Uganda.

5 Relationship between Stop TB and GFATM (CB-STB 02-02-05)

The Vice-Chair introduced the session and reported that the GFATM Secretariat was unable to attend. Two areas for discussion were outlined: a) cross representation between Stop TB and GFATM; and b) a proposed MOU between the Stop TB Coordinating Board and GFATM. The Board received a fax from Dr Richard Feachem during the meeting, in which a detailed response was given to the principles of collaboration, as stated in the letter from the Stop TB Board to GFATM. Dr Feachem's letter welcomed the drafting of an MOU.

Discussion

- 5.1 Currently, six Stop TB Board members are also seated on the GFATM Board (Canada/ UK, Japan, Pakistan, USA, WHO and World Bank). However, there is not an assigned representative from the Stop TB Board to the GFATM.
- 5.2 Several Board members expressed reservations in proceeding with an MOU between the Board and GFATM. However, in the interests of clarification and support to HBC and partners, it was decided to move forward in drafting the MOU. Partnerships will be an agenda item at the next GFATM Board

meeting in January 2003, and an MOU will help to define common objectives, operational principles and the respective roles between the Stop TB Partnership and the GFATM. The Board members recommended that the following issues be addressed in the MOU: a) clarification of coordination of support to be offered to countries; b) mechanisms for resource flows (e.g. first-line drugs through the GDF and in-kind donations such as the Novartis funds); and c) technical collaboration with the GLC for procuring second-line drugs.

- 5.3 UNAIDS has drafted a MOU with GFATM in which the above issues are addressed, including complexities of conflict of interest, additionality and absorption capacity.

Action:

- 5.3.1 The exchange of letters between the GFATM Secretariat and the Board will form the basis for further articulation of details on the relationship between Stop TB and GFATM and development of a draft Memorandum of Understanding (MOU). This draft MOU and the draft UNAIDS MOU will be circulated to the Board (*Secretariat by 22 November'02*);
- 5.3.2 A response to Dr Feachem's letter will be sent when the draft MOU has been endorsed by the Board (*Secretariat by mid December'02*);

6 Top four high TB burden countries (CB-STB 02-02-06)

Countries presented constraints, additional needs, and priorities for action by the global Partnership. During the break-out group sessions, these priorities for action were further discussed and outlined. Countries then presented the outcomes and related plans.

6.1 China

Dr Hao Yang presented the DOTS progress in China and shared that the current plan for 2005 is to achieve at least 90% DOTS coverage in the country and a cure rate of 85%. However, the target of 70% case detection cannot be achieved using the current approach and available funding. Key constraints in the programme were identified as: a) insufficient local government commitment; b) weak capacity of TB institutions; c) insufficient human resources; and d) poor collaboration and inappropriate referral of TB patients between TB dispensaries and hospitals. An action-plan, including budget, has been prepared to address these constraints.

Based on discussions in the break-out groups, the following priority actions were outlined:

- *Strengthen political commitment.* A national review of implementation of State Council TB Control Plan. Complementing this review, China requested high-level international officials to visit China to discuss review results (4th quarter 2003);
- *Strengthen hospital–dispensary collaboration.* Pilot approaches or operational research in the first half of 2003, to be expanded to five provinces (20% of the population) in the last half of 2003;
- *Strengthen human resource/management capacity.* National TB consultant team (1st quarter 2003);
- *Strengthen TB institutions in 10% of counties.*
- Budget for the above activities totals US\$ 12.6 million for the first year, which is required as additional funding.

Discussion

- 6.1.1 China National TB programme (NTP) has collaborated with the HIV/AIDS programme, and will further strengthen such links.

6.2 India

Mr Naik presented the rapid expansion of DOTS during recent years. India has the second largest programme in the world, with currently 50% of the country covered by DOTS. By 2005, the entire country will have DOTS services in place. The priorities of the Government of India towards reaching the global Stop TB targets in 2005 will focus on further expansion (population of 850 million by 2004 and 1027 million by 2005). This requires maintaining the quality of services through training of staff and an uninterrupted supply of TB drugs. Other areas that require attention are: a) supervision, monitoring and evaluation; b) multisectoral collaboration; and c) information, education and communication (IEC).

Based on discussions in the break-out groups, four priority areas were outlined:

- *Funding sustainability:* a funding gap of US\$ 19 million (October 2004–March 2005) and US\$ 50 million per year thereafter;
- *Survey to develop accurate estimates of TB incidence by state* (funding required for survey);
- *Address lack of TB awareness* through media campaign and COMBI strategy;
- *Private sector DOTS.* Pilot private-public mix (PPM) project (US\$ 2 million required), and involvement of medical colleges and NGOs.

Discussion:

- 6.2.1 In clarifying the *resource needs* of the country, the commitment of the Indian government to scale up was evident, but will continue to require external support in several areas (e.g. human resources, laboratories). In 2004, the World Bank loan will be fully utilized, and it is preferred to have government funds or alternative donor funds from this time. The Board suggested differentiating the government budget from GFATM and loans.
- 6.2.2 To avoid duplication, the Board urged one single *joint evaluation* that includes all donors of the TB programme.
- 6.2.3 In specific states in India, the DOTS programme is struggling to reach *tribal and most deprived population groups*, which account for a total of 100 million people in India. Novel initiatives and incentives are needed to support these groups.

6.3 Indonesia

Dr Haikim Rachmat presented the Indonesian TB control programme. The main obstacle for reaching the 2005 global targets is the low rate of case detection, at present 20%; at current rates of expansion the 70% rate will not be reached. There is an urgent need to: a) strengthen leadership and staffing at province level; b) to optimize and expand DOTS implementation at health centre level; c) to involve lung clinics; and d) to increase community awareness through IEC campaigns. The programme has proposed several next steps to address the above constraints, including the establishment of leadership teams in the provinces.

Based on discussions in the break-out groups, five priority areas were outlined:

- *Strengthen leadership and staffing at the provincial level* through recruitment of national consultants in 11 provinces, and additional staff and training. An further US\$ 300 000 is required;
- *Expanding DOTS coverage through health centres and other public health services*, which may require interim bridge funding until GFATM funds are received;
- *High-level monitoring mission in January 2003*;
- *Involving private health care providers* in districts where their involvement is most needed and where there is potential for the highest yield.
- *IEC strategies for increased case detection* to educate and raise awareness in communities.

Discussion:

- 6.3.1 The *GFATM funds* have not been released to the country, and no clear information on the funding disbursement is available. An intermediate solution for funding will be needed if GFATM funds are not received within the next six months. The Board was asked for support in clarifying GFATM plans on disbursing funds.
- 6.3.2 Board members raised the need for surveys and assessments to improve current *data and estimates*. It was agreed that improved surveillance at the peripheral level and among the private sector is the main requirement.

6.4 Nigeria

Dr Sofola reported on the TB programme in Nigeria, pointing out that 45% of the country is covered by DOTS. The current national rate of case detection is 15% (roughly 30% in DOTS areas). About 17.5% of the 2003 budget is met by government finances, while gaps are filled by donor and GFATM funds. The main constraints are: a) lack of political and financial commitment at state level; b) timely release of funds; c) strikes by health workers; d) ongoing restructuring of the primary health care system.

Based on discussions in the break-out groups, three priority areas were outlined:

- *Expand DOTS coverage* from 350 to 774 Local Government Areas (LGA) with external funding (lobby the GFATM) and increased internal government funding for the national TB programme (high-level missions);
- *Raise case detection in DOTS areas* through expansion of the reporting and provider network (include hospitals, academia, police, prisons, army). In addition, community mobilization and media strategies will be developed;
- *Expand TB-HIV collaboration* at national and state level.

Discussion

- 6.4.1 Lack of *political commitment* in Nigeria is related to the limited degree of government ownership, as reflected in its funding to health programmes at federal and state level. The country is now donor dependent and does not have a sustainable financing system. Once political will is created, including through high-level Board missions, it is essential that agreements are followed up through technical missions.
- 6.4.2 Nigeria, in common with many other countries, is facing difficulty with *decentralization*. TB programmes are organized centrally, while the political system is built on decentralized decision-making and resource allocation. Several Board members provided examples of how to address leadership, policy transfer from federal to state level, seminars between central and federal politicians, and channelling funds directly to decentralized level. In parallel, demand has to be created through community pressure, and partnership from state ministers and mayors through information or incentives.
- 6.4.3 The public health system has deteriorated in recent years in Nigeria, and *new providers* need to be brought in, such as patient-groups, private providers at district and primary care level, consumers, and prisons. In other countries, the TB Coalition for Technical Assistance (TBCTA) is addressing this issue through workshops bringing district personnel together (nurses, laboratories, etc.).

6.5 Top four high TB burden countries: summary and action-points

- 6.5.1 The Board welcomed the delegations of the 4 HBC and expressed strong interest in the country focused discussions. The countries were commended on their progress and thanked for the clearly outlined constraints and solutions. The Board will invite other HBC, through a similar process to outline their constraints, potential solutions and needs for Partnership support (*Secretariat will outline a proposal by January '03*);
- 6.5.2 The Board agreed with and endorsed the 4 HBC country plans, in support of which the Board will act as broker between countries and donors, including the GFATM. A plan will be developed to outline Board support to these countries (*Secretariat and DEWG by end Nov. '02*), and progress will be reported in the next Board meeting (*Secretariat*);
- 6.5.3 The Board will respond to country requests for high-level missions, and: a) aim to reach the highest level of political buy-in to Stop TB on country-specific topics; b) build political will within countries at State-/Congress/National Assembly-level, where appropriate. The Secretariat will develop an operational plan for high-level missions (*Secretariat and DEWG by end November '02*);
- 6.5.4 The commitments made during high-level missions will be followed up by technical mission to ensure implementation of political commitments. Regular updates on planned technical monitoring missions will be sent to Board members. Mission reports and lessons learned on specific country strategies will also be made available (*DEWG and Secretariat-ongoing*);
- 6.5.5 DEWG will prepare guidance for program managers on decentralization (*DEWG by January '03*).
- 6.5.6 A strategy to further involve new actors and local communities in the Stop TB partnership at all levels will be developed (*DEWG and Secretariat*).

7 Country obstacles—global issues (CB-STB 02-02-07)

7.1 Lessons learned from UNAIDS

Dr Catherine Hankins presented UNAIDS activities and priorities, and areas of interest related to TB.

Discussion

- 7.1.1 Board members pointed out the need for stronger collaboration on technical issues, such as antiretrovirals (ARV) and country-level collaboration between AIDS and TB coordinators.

7.2 Human resources: obstacles and proposed solutions

Dr Gijs Elzinga outlined the urgent need to address the lack of human capacity for dealing with TB and HIV/AIDS. A draft discussion paper was presented to brief the Board and to obtain their comments on franchising as a strategy to increase access to TB-HIV care in sub-Saharan Africa.

Discussion:

The Board expressed concern and support over the new strategic direction. It recommended feasibility study and piloting before proceeding with *franchising*. Risks which would need to be addressed include bypassing or harming national TB programmes, undermining integrated approaches to health systems, and the insecurity around ARV delivery. Such an approach will need to be adapted to the local community situation, and requires customer orientation and good quality of health services. The World Bank offered to share experience in franchising with respect to child health, and Management Sciences for Health (MSH) offered to share experience with respect to pharmaceuticals.

7.3 Communications, advocacy and community mobilization

Dr Nils Billo presented current development on Communication for Behavioural Impact (COMBI) projects. Pilot projects are being carried out in Bangladesh, India (Kerala State) and Kenya. The importance of DOTS focused on serving the poorest of the poor, and the involvement of nurses in TB control programmes, was emphasized.

Discussion:

7.3.1 The Board supported the activities on community mobilization, changing behaviour, and creating demand for DOTS (where services are in place). Discussions emphasized that clear messages need to be tailored to the appropriate target group and situation, and through local channels, i.e. local advertisement industry, experiment with TV spots, theatre, folklore groups, music.

7.4 Private-public mix

Dr Mukund Uplekar presented the progress of the PPM initiative, which is part of the DEWG. Several models and their current impact were highlighted. Immediate next steps to target urban areas where the private sector thrives were outlined. DOTS should initially partner with institutions, hospitals or NGOs, and through them, individual practitioners in their areas. Six countries are priorities for implementation, if the funding gap of US\$ 2.5 million can be bridged: Bangladesh, India, Indonesia, Kenya, Pakistan, Philippines.

Discussion:

7.4.1 Supervision and quality control are the main challenges for PPM.

7.5 Country obstacles—global issues: summary and generic discussion

It is clear that new initiatives and developments are required to further increase TB case detection. Such initiatives need to address: a) the provision of services through community approaches and addressing patient constraints; b) advances in new technology; c) involving the private sector; and d) enhancing human resource capacity. The Board expressed its strong support and requested pragmatic assessment of the impact of such initiatives.

Action:

7.5.1 Develop specific proposals on new initiatives for increasing case detection (*DEWG*).

8 Stop TB Partnership Secretariat workplan and budget (CB-STB 02-02-08)

Dr Jacob Kumaresan presented the workplan and budget of the Secretariat. Three main areas of activity were outlined: GDF, partnership, and communications and advocacy, together with the related priorities for 2003. The workplan is in a logframe format that allows the Secretariat to monitor progress and financial status.

Discussion:

- 8.1 The Board *supported the workplan and budget* and welcomed the format of the workplan, which it felt was detailed, transparent and accountable. It proposed that a sub-committee of the Board review the 2004 workplan and plan before final presentation to the Board.
- 8.2 The *financial figures of the budget* were clarified. No funds are yet in place for the 2003 budget. The reduction in staff costs is attributable to more accurate budgeting based on actual staff costs, and there are more secondments. The Board requested the addition of an income–expenditure report;
- 8.3 Several issues concerning the *GDF workplan and budget* were clarified: a) budget; b) expansion; c) branding. It is expected that 50% of the GDF budget will be income from direct procurement, including that from the GFATM. The other 50% is expected to come to the Secretariat/GDF, either through the Trust fund or through WHO channels. Possible expansion to malaria drugs and diagnostics are not

part of the current GDF budget, and will be assessed through a feasibility study. GDF branding activity is intended to ensure that drugs are of high quality, low cost, and reliably supplied, and to avoid "leakage" from the public to private sector within country and to other countries.

Action:

- 8.3.1 Future plans and budget for the GDF and Partnership Secretariat will be presented separately (*Secretariat to present to the Board in Fall'03*).

9 Other issues (CB-STB 02-02-09)

9.1 GDF evaluation

Ms Nina Schwalbe outlined the process for undertaking the GDF evaluation, and made a plea for participation by Board members. Funding for the evaluation will be provided by DFID, OSI (though the proposed Stop TB Trust Fund) and the Secretariat, using World Bank funds.

Action:

- 9.1.1 The Board agreed the process for the GDF evaluation, but questioned the need for a separate feasibility study for an expanded GDF scope, as the Terms of References seem to overlap. The Secretariat will discuss the feasibility study with the subgroup of the Board established for the GDF evaluation;
- 9.1.2 An adjudication committee has been formed and will meet in New York on 27 November 2002 to review the GDF evaluation proposals. This committee includes the following Board members: Emma Back, JW Lee, Nina Schwalbe, and PR Narayanan. Additional Board members are welcomed to the committee.

9.2 Harmonization of GDF and GLC operations

Dr Jim Yong Kim presented a letter from the DOTS Plus Working Group proposing next steps in convergence between the GDF and the GLC.

Discussion:

- 9.2.1 The Board endorsed the letter from the DOTS Plus Working Group setting out the next steps for GDF and GLC convergence, and confirmed that resources to purchase second-line drugs will come primarily from the GFATM. Additional resources will be needed for technical assistance (including proposal development, review and monitoring) and administration.

9.3 Financing issues

Mr Chris Lovelace outlined the process of development for the Stop TB Trust Fund.

Discussion:

- 9.3.1 The Board members were given until 8 November to provide specific comments or corrections on the letter to be signed between the World Bank and the Coordinating Board. If no changes are suggested, the Chair of the Board will sign the letter and the World Bank will proceed to work with the first donors interested in contributing to the Trust Fund (DFID, OSI and CIDA) in developing administrative agreements for its operation.

Action:

- 9.3.2 World Bank to finalize the clearance process and initiate individual agreements with DFID, OSI and CIDA (*World Bank by 22 November*).

9.4 Next Stop TB Coordinating Board meeting

It was proposed to hold the next Board meeting in New Delhi, India, back-to-back with the Regional Stop TB forum, which will be held on 13–14 February 2003. Another option is to organize the meeting in parallel with a World TB Day event, thus giving profile to a specific country event around 24 March.

Action:

- 9.4.1 The Secretariat will explore opportunities for the next Board meeting to be held in the first quarter of 2003 (*Secretariat by end November'02*).

Stop TB Coordinating Board meeting

28-29 October 2002

Final Agenda

OBJECTIVES

1. Formulate priorities and identify opportunities for action to support the top 4 high TB countries in reaching the global Stop TB targets;
 2. Further clarify the relationship between Stop TB and the GFATM;
 3. Identify support in addressing systemic challenges (health systems, human resources, private sector) for country TB programmes;
 4. Endorse the 2003 workplan and budget for the Stop TB Partnership Secretariat;
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Monday 28 October 2002

Chair: Ernest Loevinsohn

Documents

08:45–09:00 Welcome

Introduction of participants and adoption of agenda—*Chair*

09:00–11:00 Reaching the Global Stop TB targets

09:00-09:30 Global TB situation: epidemiological analysis—*Chris Dye*

09:30-10:00 Global DOTS Expansion: status, constraints and solutions—Mario Raviglione

10:00-11:00 *Discussion*

1. Progress DOTS Expansion

11:00–11:30 Coffee/Tea

2. GFATM relation Stop TB

11:30–12:30 GFATM and Global Partnership to Stop TB

11:30-12:00 Relation GFATM & Stop TB—*GFATM Secretariat*

12:00-12:30 *Discussion and decision*

- *Actions from Board and Secretariat*

13:00–14:00 Lunch Break

14:00–17:30 Country Obstacles: Top 4 high TB burden countries

14:00-15:00 Country presentations: *based on the existing DOTS Expansion plans, analysing constraints and additional needs, and formulate priorities for action for the global Partnership to support the top 3-5 high TB countries in reaching the global Stop TB targets and in maintaining achievements towards TB elimination.*

- China—Hao Yang
- India—S.K. Naik
- Indonesia—Haikim Rachmat
- Nigeria—Oleyemi Sofola

3. Constraints & solutions in 4 HBC

15:00-15:30 Questions

15:30–16:00 Coffee/Tea

16:00-17:30 Break-out groups (4): Discussion of proposed solutions in each country

4. Country Obstacle Questions

17:30 Adjourn

19:00 Dinner for Board members and invited guests

Tuesday 29 October 2002

Chair: Ernest Loevinsohn

Documents

09:00-12:30 Country Obstacles: Top 4 high TB burden countries—continued

09:00-10:30 Break-out groups (4): discussion of proposed solutions in each country

10:30–11:00 *Coffee/Tea*

11:00-11:40 Presentations of the break-out groups (4) *each 10 minutes*

11:40-12:30 *Discussion and decision*

- *Report on next steps for each of the 4 countries*
- *Process for assessment in other countries*
- *Actions from Board and Secretariat*

12:30–13:30 *Lunch Break*

13:30–15:30 Country obstacles: Global Issues

13:30-13:40 TB and health systems capacity—*Mario Raviglione*

13:40-13:50 “Readiness for scaling up—lessons learned from UNAIDS”—*Catherine Hankins, UNAIDS*

13:50-14:00 Human resources: obstacles and proposed solutions—*Gijs Elzinga*

14:00-14:10 Communication, advocacy and community mobilization—*Nils Billo*

14:10-14:20 Private Public Mix—*Mukund Uplekar*

14:20-15:30 *Discussion and decision*

- *Discussion*
- *Actions from Board and Secretariat*

15:30–16:00 *Coffee/Tea*

—Next session is for Coordinating Board members only—

16:00-16:45 Partnership Secretariat workplan/ budget 2003

16:00-16:15 Presentation of the workplan—*Jacob Kumaresan*

16:15-16:45 *Discussion and decision*

- *Endorsement of the workplan*

16:45-17:15 Other issues and next steps

- *GDF evaluation—Nina Schwalbe*
- *GLC-GDF harmonization of operations—Jim Yong Kim*
- *Financing issues—Chris Lovelace/ Ernest Loevinsohn*
- *Other issues*

17:15-17:45 *Discussion*

18:00 Adjourn

5. Health
McDonald's down
the Desert-The
Concept

6. Private-public
Mix

7. Secretariat
Workplan '03/draft
(Circulated through
email beforehand)

8. GLC/GDF

9. MOU Trust fund*

10. TB & poverty

Wednesday 30 October 2002

Site visits in the Western Cape province/ meeting with South African Minister of Health—organized by the South African, Department of Health

Thanks to the Open Society Institute/ Soros Foundation for hosting the meeting, at:

Meeting venue and accomodation: *The Lord Charles Hotel*, Corner of Faure and Stellenbosch Roads, Somerset West, 7130, Cape Town, South Africa, Tel: 27 21 855 1040, Fax: 27 21 855 1107

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