

# The Stop TB Partnership ANNUAL REPORT 2006

A portrait of progress



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## SAVING LIVES

The Patients' Charter for Tuberculosis Care – the first global patient-powered standard for care developed by patients around the world was launched in 2006. The charter empowers people with TB and their communities through knowledge of the disease.

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## THE GLOBAL PLAN TO STOP TB (2006–2015)

Launched at the World Economic Forum in January, the Global Plan sets a roadmap for eventually eliminating TB as a public health problem. Full implementation of the Plan will save some 14 million lives.

## Message from Marcos Espinal, Executive Secretary

It would be fair to say that 2006 was a watershed year for the Stop TB Partnership, marked by two major landmarks.

The Global Plan to Stop TB, 2006–2015, which was launched at the World Economic Forum in January, set out a roadmap for controlling and eventually eliminating TB as a public health problem. Full implementation of the Global Plan will save approximately 14 million lives, provide treatment for 50 million people, and aims to tackle multidrug-resistant TB and TB/HIV co-infection. Development and introduction of new tools for TB control is another major aim of the Global Plan.

Former President of Portugal Dr Jorge Sampaio, appointed as the UN Secretary-General's Special Envoy to Stop TB, embarked on a busy schedule, attending such events as the UN General Assembly on HIV/AIDS and the Clinton Foundation Summit and writing to G8 leaders to encourage them to prioritize TB for discussions at the St Petersburg Summit.

High-level advocacy missions, wide endorsement of the 'Call to Stop TB' awareness campaign, and the launch of the Patients' Charter for Tuberculosis Care – the first global patient-powered standard for care developed by patients around the world – all heightened the Partnership's profile in 2006.

Despite these exciting recent developments, we still face major hurdles. The emergence of XDR-TB highlights the urgent need to speed up both the development of new tools and the translation of the Global Plan's strategic directions into operational plans at country level.

Addressing the health workforce crisis and the constraints associated with inadequate health systems remains a great challenge, and there is increasing competition for resources among public health initiatives, development initiatives and other humanitarian causes.

It is a time for reflection on the current role and future direction of the Stop TB Partnership. In that spirit, the Coordinating Board, at its meeting in Jakarta, Indonesia, in November 2006, commissioned an independent external evaluation that will look at the Partnership's impact on TB control.

Many world leaders have shown that they understand the magnitude of the global TB crisis, but partners need to work together to convert this understanding into political will. We have moved forward steadily, but we are not there yet – high-level advocacy is still needed to drive policy change and increase funding for TB control and prevention.

**Marcos Espinal**  
Executive Secretary, Stop TB Partnership

## Executive summary

“ In 2006,  
the Global Drug Facility (GDF)  
of the Partnership  
approved access to  
3.3 million anti-TB drug  
patient treatments. ”

The Global Plan to Stop TB, 2006–2015 (the Global Plan), was launched in Davos, Switzerland, in January 2006. This Plan, which is underpinned by the WHO Stop TB Strategy, is a comprehensive assessment of the actions and resources needed to move forward on TB control and make an impact on the global TB burden. It calls for wider and deeper engagement of all partners.

By the end of 2006, the Stop TB Partnership comprised 517 partners, 54 more than in 2005. The Call to Stop TB was launched on World TB Day 2006 to rally established partners and others who share the concern to tackle TB in order to alleviate poverty and prevent death. It attracted nearly 700 signatories including former Secretary-General Kofi Annan, President Gloria Arroyo, Prime Minister Tony Blair, and Bishop Desmond Tutu. The former President of Portugal Jorge Sampaio took up the baton as the UN Secretary-General's Special Envoy to Stop TB and conducted many high level advocacy missions for the Partnership. The Patients' Charter for Tuberculosis Care, the first global "patient-powered" standard for care developed by patients around the world, was launched in March 2006. The Kochon Prize, which marks outstanding contributions to the global fight against TB, was awarded to Mr Winstone Zulu, a leading TB/HIV activist from Zambia, and Indian TB Programme Manager Dr LS Chauhan.

The International Federation of Red Cross and Red Crescent Societies collaborated with the Stop TB partnership to provide the expertise and momentum to establish a Stop TB Partnership for Europe, to cover the WHO European Region which includes Central Asian countries.

As a result of efforts by the Advocacy, Communication and Social Mobilization (ACSM) Subgroup at country level, approximately US\$ 30 million was approved in the sixth round of Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) grants to design, implement, and monitor ACSM activities in 30 countries. Overall, TB proposals achieved their highest success rate to date (64%) of proposals submitted to the Global Fund, and highest for any of the three diseases.

In 2006 the Global Drug Facility (GDF) of the Partnership approved access to 3.3 million anti-TB drug patient treatments. It approved 43 countries for new grants and placed new orders totalling US\$ 29 million for recipients of its grants. GDF brokered technical assistance missions to 58 countries by drug management and TB experts. The procurement functions of the Green Light Committee (GLC) were merged with GDF. During the year GLC approved 24 applications covering more than 12 000 patients with multidrug-resistant TB (MDR-TB); double the number in 2005. Significant progress has been made in the development pipeline of new drugs, vaccines and diagnostics.

During 2006 intensive resource mobilization efforts following the launch of the Global Plan led to the total income of the Stop TB Partnership Secretariat rising to US\$ 58 million; a 69% increase over 2005 (US\$ 34.4 million). The resources entrusted to the Partnership were prudently managed, and accounting was in line with international best practice and WHO's rules and regulations.

The main constraints to full implementation of the Global Plan to Stop TB are lack of the required political support and insufficient funds to implement the full plan. Funds are urgently needed to address the health workforce crisis, the constraints associated with inadequate health systems in countries, and problems outside the health sector that impinge on its performance. There is increasing competition for resources among public health initiatives, development initiatives and other humanitarian causes. The recent emergence of extensively drug-resistant TB highlights the urgent need to speed up the development of new tools and for an increased focus on translation of the Global Plan's strategic directions into operational plans at country level. Partners need to get fully engaged in the fight to control and eventually eliminate TB. This reflection on the current role and future direction of the Stop TB Partnership is expected to be taken further with the independent external evaluation of the Partnership, commissioned by the Coordinating Board at its meeting in Jakarta, Indonesia, in November 2006.

## List of abbreviations

### ACOETIS

Agence de Coordination en Etudes Internationales de Santé

### ACSM

Advocacy, communication and social mobilization

### AGA

Afro Global Alliance

### AIDS

Acquired immunodeficiency syndrome

### APPG

All Party Parliamentary Group on Global Tuberculosis

### ART

Antiretroviral therapy

### ASET [Comas]

Asociación de Enfermos de Tuberculosis "Victoria Castillo de Canales"

### BCG

Bacille Calmette-Guérin

### CDC

Centers for Disease Control and Prevention [USA]

### CEO

Chief Executive Officer

### CIDA

Canadian International Development Agency

### CPT

Co-trimoxazole preventive therapy

### DEWG

DOTS Expansion Working Group

### DFID

Department for International Development [United Kingdom]

### DOTS

The internationally recommended strategy for TB control

### ECDC

European Centre for Disease Prevention and Control

### EU

European Union

### FIND

Foundation for Innovative New Diagnostics

### GDF

Global Drug Facility

### GLC

Green Light Committee

### HBC

High TB burden country

### HIV

Human immunodeficiency virus

### ISAC

Intensified Support and Action in Countries

### ISO

International Organization for Standardization

### ISTC

International Standards for Tuberculosis Care

### KNCV

Royal Netherlands Tuberculosis Foundation

### LAMP

Loop-mediated isothermal amplification technology platform

### LED

Light-emitting diode

### LHL

Norwegian Association of Heart and Lung Patients

### MDGs

Millennium Development Goals

### MDR-TB

Multidrug-resistant tuberculosis

### MGIT

Mycobacterial growth indicator tube

### NTP

National TB control programme

### NGO

Nongovernmental organization

### PEPFAR

President's Emergency Plan for AIDS Relief [USA]

### PIH

Partners in Health

### PPM

Public-private mix

### SAMRC

South African Medical Research Council

### SLCS

Subgroup for laboratory capacity strengthening

### SRL

Supranational TB reference laboratory

### TB

Tuberculosis

### TB/HIV

Tuberculosis and HIV

### TBTEAM

TB Technical Assistance Mechanism

### TBVAC

TB vaccine cluster

### UN

United Nations

### USAID

United States Agency for International Development

### WHO

World Health Organization

### XDR-TB

Extensively drug-resistant tuberculosis

## Introduction

### The highlights of 2006 were:

- the launch of the Global Plan to Stop TB, 2006–2015 (the Global Plan)
- the launch of the WHO Stop TB Strategy
- the appointment of the first UN Secretary-General's Special Envoy to Stop TB, Dr Jorge Sampaio
- impressive progress in TB case detection and cure rates
- documentation of the emergence of extensively drug-resistant TB (XDR-TB)

**The Global Plan** launch took place at the World Economic Forum in Davos, Switzerland, with President Olusegun Obasanjo of Nigeria, Chancellor Gordon Brown of the United Kingdom of Great Britain and Northern Ireland, and Bill Gates, Chairman of the Microsoft Corporation, and was accompanied by many satellite events throughout the world highlighting the importance of a massive global effort to control and eventually eliminate TB. The Global Plan is a comprehensive assessment of the action and resources needed to roll out the Stop TB Strategy and make an impact on the global TB burden.

**The WHO Stop TB Strategy** (Box 1) builds on the DOTS strategy and expands its scope to address the remaining challenges to TB control; an expansion that is critical to achieve the Millennium Development Goals (MDGs) and Stop TB Partnership targets.

**UN Special Envoy**

Former President of Portugal Dr Jorge Sampaio took up the challenge to become the first UN Secretary-General's Special Envoy to Stop TB. He said that "the success of the Partnership's Global Plan to Stop TB requires on the one hand, mobilization of the necessary resources and on the other, strong political commitment from all countries to fully implement the actions set out in the Plan". Dr Sampaio undertook a very active advocacy role during 2006 (see page 16).

**Case detection rates**

The catalysing effect of the Stop TB Partnership since its launch and endorsement by the Amsterdam Ministerial conference and the World Health Assembly in 2000 are reflected in the improvement of TB case detection achieved by countries. The average annual increment of new smear-positive cases notified under DOTS and reported to WHO from 2000 to 2005 was 243 000 compared to about 134 000 from 1995 to 2000 (see Figure 1).

Despite such impressive progress globally the 2005 targets of 70% case detection and 85% cure were narrowly missed; case detection was 60 % (95% confidence limits 52–69%) and treatment success was 84%. Progress towards the 70% case detection target can be said to have been fuelled *inter alia* by the Stop TB Partnership. The rapid expansion in the financial resources made available to the Stop TB Partnership over the period 2000 to 2006 is a further evidence of the value stakeholders put on the work of the Partnership.

**The emergence of XDR-TB**

The emergence of XDR-TB highlights the urgent need to speed up the development of new tools and to focus on translation of the Global Plan's strategic directions into operational plans at country level.

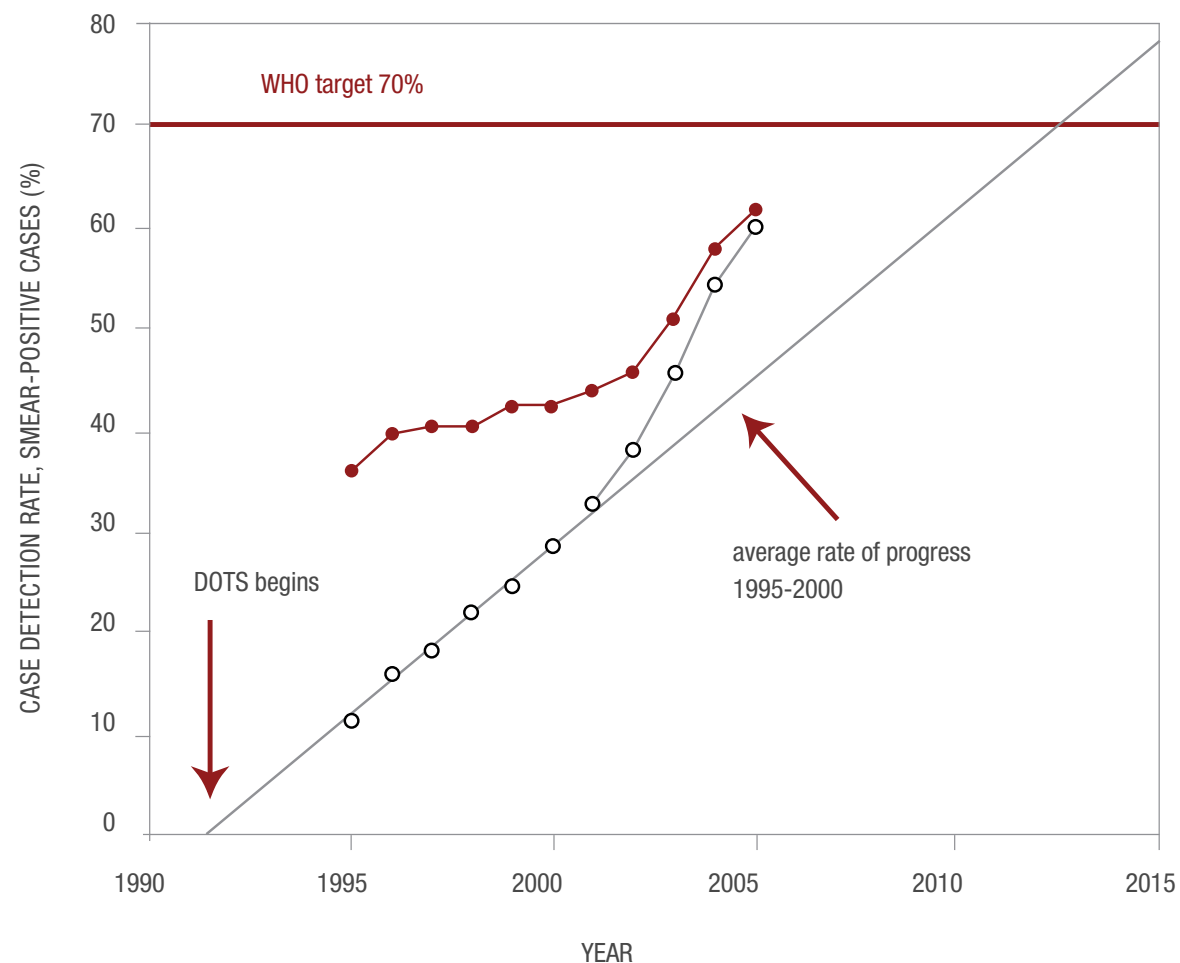
The activities of the Stop TB Partnership are classified and described in this report under the following main areas:

- Governance and planning
- Partner engagement
- Advocacy, communication and social mobilization
- Working Groups
- Global Drug Facility
- Resource mobilization and financial management.

**BOX 1: Stop TB Strategy Components**

- Pursue high-quality DOTS expansion and enhancement
- Address TB/HIV, MDR-TB and other challenges
- Contribute to health system strengthening
- Engage all care providers
- Empower people with TB, and communities
- Enable and promote research

**Figure 1: Progress towards the 70% case detection rate<sup>1</sup>**



<sup>1</sup> Open circles mark the number of new smear-positive cases notified under DOTS 1995–2005, expressed as a percentage of estimated new cases in each year. The solid line through these points indicates the average annual increment from 1995–2000 of about 134 000 new cases, compared to the average increment from 2000–2005 of about 260 000 cases. Closed circles show the total number of smear-positive cases notified (DOTS and non-DOTS) as a percentage of estimated cases. (Global Tuberculosis Control: Surveillance, planning, financing. WHO Report 2007. Geneva, World Health Organization. (WHO/HTM/TB/2007.376).



## KEY EVENTS

Two Coordinating Board meetings, several meetings of the Working Groups, launch of the Kochon Prize and the launch of the Global Plan to Stop TB were important events in the life of the Partnership in 2006.

# Governance & planning

The Partnership Secretariat continues to communicate progress and to act as an ambassador for Stop TB. Governance mechanisms of the Stop TB Partnership are kept well aligned and sensitive to the engagement, representation, and participation of all partners, ensuring transparency and accountability in decision-making and resource utilization. During 2006 the Secretariat was restructured and strengthened to streamline management procedures and to support the much increased reporting requirements of donors since multiyear agreements became operationally effective.

The Stop TB Partnership Coordinating Board met twice in 2006 and the Executive Committee held five teleconferences.



### Coordinating Board Meeting, Abuja, Nigeria, 24–25 April

- Discussed progress in the fight against TB in Africa; called for the development of a TB research movement; endorsed the establishment of a Task Force on Retooling; welcomed new action plans on TB & Poverty and strengthening the laboratory network; agreed to set up a business advisory group for GDF and discussed plans for the upcoming African and European Ministerial meetings.

- Endorsed the appointment of Irene Koek, Chief of the Infectious Diseases Division, Bureau for Global Health at the United States Agency for International Development (USAID) as the new Chair of the Stop TB Partnership Coordinating Board. Ernest Loevinsohn of the Canadian International Development Agency (CIDA) was appointed Emeritus Chair.

- Created additional seats on the Board to reflect the importance and growing voice of TB patients and their affected communities, and the interest of the Government of Italy to participate as a donor partner.

- A delegation of Board members visited Nigerian President Olusegun Obasanjo; a mission which helped to ensure that TB remained high on the domestic political agenda in Nigeria throughout 2006.

### Coordinating Board Meeting, Jakarta, Indonesia, 29–30 November (in conjunction with a meeting of Partners for TB Control in South Asia)

- Endorsed a “Call to Stop TB in Asia”; agreed on a process to evaluate the added value and impact of the Partnership during 2007; discussed the emergence of XDR-TB and the upcoming study led by the World Bank on the economic implications of TB; established a process for monitoring the implementation of the Global Plan; and endorsed a guideline on New Technologies for TB Control.

- Mandated the Secretariat to begin planning for a 2009 Partners’ Forum; the highest decision-making body of the Stop TB Partnership and critical for accountability with stakeholders.

- The meeting was addressed by the Minister of Health of Indonesia, the WHO Regional Director for South-East Asia, WHO Assistant Director-General for HIV, TB and Malaria and the UN Secretary-General’s Special Envoy to Stop TB, Dr Jorge Sampaio.

- A delegation of the Partnership met with the Vice-President of Indonesia, Yusuf Kala, and stressed the need for the Indonesian Government to continue prioritizing activities related to TB control. The Vice-President reassured the delegation of support to the national TB control programme at the highest level.

### The Kochon Prize

Established in 2006 to mark outstanding contributions to the global fight against TB, the prize was awarded to leading TB/HIV activist Mr Winstone Zulu from Zambia, and Indian TB Programme Manager Dr LS Chauhan by the Kochon Foundation Chairman Mr Doo-Hyun Kim and Stop TB Partnership Executive Secretary Dr Marcos Espinal during the Thirty-seventh Union World Conference on Lung Health in Paris in November 2006.

### Implementation of the Global Plan

With the ambitious targets of the Global Plan, there is a need to maximize output of the mechanisms designed to coordinate the Partnership effectively and to monitor progress in implementation (Box 2).

The main constraints to full implementation are:

- lack of financial resources and increasing competition for resources among public health initiatives, development initiatives and humanitarian causes.
- lack of political engagement to honour commitments;
- lack of engagement by partners;
- the health workforce crisis, i.e. the qualitative and quantitative lack of human resources capable of implementing control efforts in endemic countries;
- constraints associated with health systems infrastructure and basic infrastructure outside the health sector;

There is need to think creatively and fully engage all Stop TB Partners to meet these challenges.

### Box 2: Monitoring and evaluating Working Group achievements against the targets in the Global Plan to Stop TB, 2006–2015

At its meeting in November 2006, the Stop TB Coordinating Board strongly endorsed the need to establish a monitoring system for the Global Plan.

A monitoring and evaluation focal point has been identified by each Working Group, WHO region and by the Secretariat and from 2007 they will report annually against the targets and indicators in their individual strategic plans.

A simple standard template for the collection of monitoring and evaluation parameters and a streamlined process focusing on substantive impact indicators rather than process indicators are under development.

There will be a review of reports, and presentation and dissemination of the results to relevant audiences. The overall report on progress in the implementation of the Global Plan will be published annually starting in 2008. Less formal biannual updates will be made to the Coordinating Board.



## FIGHTING TB TOGETHER

Partners are the lifeblood of the Stop TB movement. The Advocacy, Communication and Social Mobilization Working Group now includes a task force for building national partnerships.

# Partner engagement

### Strengthening the coalition of partners

The network of partners was consolidated further during 2006 and at the end of the year comprised 517 partners, 54 more than at the end of 2005. The geographic spread and nature of these partner organizations is shown in Table 1 and Figure 2, and their activities are profiled in the Partners Directory, available at the Stop TB web site ([www.stoptb.org](http://www.stoptb.org)).

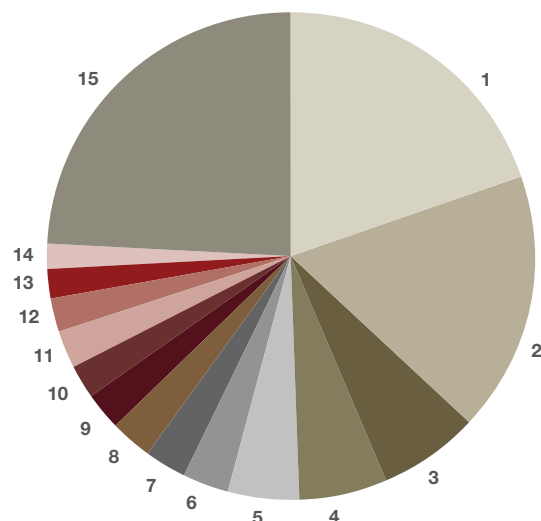
In 2006, 12 partners were profiled on the Stop TB web site: the Damien Foundation, the International Union Against Tuberculosis and Lung Disease, the Tuberculosis Survival Project, the Norwegian Association of Heart and Lung Patients, TB Alert, TB Care Association, the Afro Global Alliance, the International Pharmaceutical Students' Federation, ASET Comas, Agence de Coordination en Etudes Internationales de Santé, Icons of Europe, and Destination Santé.

**Table 1: Classification of partners of the Stop TB Partnership**

Organization type	Number of partners in 2006
Academic institution	46
Donor organization	10
For-profit corporation	34
Governmental organization including technical agencies	35
Intergovernmental organization	14
Nongovernmental organization: foundation	54
Nongovernmental organization: general	231
Nongovernmental organization: network	54
Other	39
<b>TOTAL</b>	<b>517</b>

**Figure 2: Classification of partners of the Stop TB Partnership by country**

Country	Number of partners in 2006
1 United States of America	96
2 India	84
3 Pakistan	32
4 Nigeria	29
5 United Kingdom	22
6 Ghana	15
7 Kenya	14
8 South Africa	13
9 Indonesia	12
10 Canada	12
11 Netherlands	12
12 Bangladesh	11
13 France	9
14 Switzerland	8
15 Others (countries with < 8 partners)	148
<b>TOTAL</b>	<b>517</b>



### Enhancing outreach to partners

Two initiatives launched in 2006 increased outreach to partners:

- The Call to Stop TB, launched on World TB Day 2006, is a rallying slogan for Stop TB partners and others who share our concern that TB can and must be addressed to alleviate poverty and prevent needless deaths. It attracted nearly 700 signatories during the year, including the UN Secretary-General Kofi Annan, President Gloria Arroyo, former Prime Minister Tony Blair, and Bishop Desmond Tutu.

- The first global "patient-powered" standard for care, developed in tandem with the International Standards for Tuberculosis Care (see page 27) to promote a "patient-centred" approach, was launched as the Patients' Charter for Tuberculosis Care (the Charter).

### Supporting national and regional partnerships to achieve their objectives

The Stop TB Partnership for Europe, launched by the International Federation of Red Cross and Red Crescent Societies in October 2006, made significant strides during the year (see Box 3).

Steps were taken to launch new partnerships and to assess the contributions made by existing ones through the following key events.

- A task force for building national partnerships was set up under the umbrella of the Advocacy, Communication and Social Mobilization Working Group.

- National partnerships in Ghana and Peru were launched in 2006 to join those in Brazil, Canada, Indonesia, Islamic Republic of Iran, Italy, Mexico, Pakistan, Sudan, Uganda, and the USA. National partnerships to Stop TB bring all national stakeholders together to raise awareness for greater engagement and commitment.

The success of the Stop TB Partnership depends on the work of all of its partners. This section highlights the profiles of a few partners and projects led by them.

### The Norwegian Association of Heart and Lung Patients

The Norwegian Association of Heart and Lung Patients (LHL), Norway's largest patients' organization, emphasizes the role of self-help and peer support in overcoming heart and lung diseases. LHL carries out sociopolitical and

lobbying work as well as supporting TB programmes and projects in seven countries. The Association's goal is to help persons suffering from illness or disability to participate in society on an equal basis.

### Afro Global Alliance

The Afro Global Alliance (AGA), founded in 2003, is a non-profit-making NGO with headquarters in Nigeria and offices in Ghana and with a growing number of affiliates around the world. One of its aims is fight against infectious diseases such as TB, HIV and malaria through education. AGA's strategy is to make an impact through joining and initiating partnerships and it has programmes in TB control, advocacy and implementation. Volunteers in the health sector are closing the communication gap between rural and urban populations by reaching communities in the languages they understand. AGA believes that "if an individual is affected, the community is affected". ([www.afroglobal.org](http://www.afroglobal.org))

### Agence de Coordination en Etudes Internationales de Santé (ACOETIS)

With the backing of international organizations and civil society, ACOETIS provides multidisciplinary expertise in the coordination of national and international health programmes, and promotes sustainable development in developing countries through skills transfer. The mission of ACOETIS is that equitable access to quality care should be a reality for people living with TB and AIDS. This international not-for-profit organization is currently present in six developing countries. ([www.acoetis.org](http://www.acoetis.org))

### The Tuberculosis Survival Project

The Tuberculosis Survival Project, a web-based project launched on World TB Day 2006, is a patient-led initiative that aims on the one hand, to inform and raise awareness of TB, and on the other, to provide peer support to those being treated for MDR-TB. The project offers current TB news, a news archive and a place on the web site where people can write about their own experience with TB

**Box 3: Confronting the TB emergency in Europe**

The International Federation of Red Cross and Red Crescent Societies played a key role in providing the expertise and momentum to establish a Stop TB Partnership for Europe, to cover the WHO European Region which includes Central Asian countries. Such a partnership was considered to be critical to confronting TB and, in particular, MDR-TB which threatens Europe. Some highlights of its activities were:

- outreach to 30 leading European health, donor and advocacy organizations to join the new partnership;
- agreement on main goals, structure, and an initial 10-point Action Plan;
- generation of high-level media coverage of the partnership launch across Europe and globally;
- meetings with senior-level EC officials and permanent missions of countries in line to assume the EU presidency (Germany, Portugal and Slovenia);
- formation of an influential "Brussels group" to lead advocacy efforts vis-à-vis the European Commission and Parliament;
- mobilization of the Federation Secretariat and selected Red Cross Societies in EU countries (France Germany, Sweden, United Kingdom) to support Partnership activities;
- inclusion of financial support for activities of the Coordinating Office in the annual appeal of the Federation for 2007.

and MDR-TB. The Tuberculosis Survival Project aims at "helping people with TB/MDR-TB to help themselves". The site is supported by an unrestricted educational grant from Eli Lilly and Company. ([www.tbssurvivalproject.org](http://www.tbssurvivalproject.org))

# Advocacy, communication, and social mobilization



## SPREADING THE WORD

Advocacy and communication are key functions of the Secretariat, which provides high-quality information on TB prevention, diagnosis and treatment and new tools to broad audiences through a variety of channels.

### Placing TB on the global development agenda

The most compelling advocacy event of 2006 was the launch of the **Global Plan to Stop TB, 2006–2015**, at the World Economic Forum in Davos, Switzerland, and at a series of events in London, Moscow, Nairobi, Ottawa, Paris, and Washington, DC.

Several prominent persons gave their support in order to raise the profile of TB; including Dr Jorge Sampaio, UN Special Envoy to Stop TB (see Box 4), the former President of Zambia Kenneth Kaunda, and Mr Michael Barnier, former French Minister of External Affairs. Several national Stop TB Partnerships have appointed their own high-profile Stop TB champions. In 2007 this area will be developed through the Call to Stop TB campaign.

**Box 4: UN Special Envoy lends his active support to the Stop TB Partnership**

Former President of Portugal Dr Jorge Sampaio took up the challenge to become the first UN Secretary-General's Special Envoy to Stop TB. He defined his main principles for action during this first period as threefold:

- urging world leaders to follow through on political commitments;
- assessing the current status of TB control and identifying achievements, shortfalls, expectations and results;
- determining how to mobilize additional resources in order to fill the funding gap for TB control.

To deliver on these principles, Dr Sampaio embarked on a busy schedule of meetings and events throughout the second half of 2006, including:

- attendance at the UN General Assembly Special Session on HIV/AIDS (UNGASS) and meeting the UN Secretary-General;
- writing to all the G8 leaders encouraging them to prioritize TB for discussions at the St Petersburg Summit;
- preparing a message for the Summit of Portuguese-speaking countries held in Guinea-Bissau in July 2006;
- urging Health Ministers at the Fifty-sixth Regional Committee for Africa in Addis Ababa, Ethiopia, to develop national plans to combat the TB emergency;
- meeting with several world leaders at the Clinton Global Initiative Annual Meeting with José Manuel Barroso, President of the European Commission; and with Enrique Iglesias, Secretary-General of the Ibero-American Community. The Ibero-American Heads of States Summit, held in Uruguay in November 2006, adopted a statement on TB;
- delivering opening addresses at the European CEO Summit on Business and AIDS – an opportunity to encourage improved TB/HIV collaborative activities and outline opportunities for private sector involvement in the fight against TB; and at the inaugural session of the Thirty-seventh Union World Conference on Lung Health in Paris, France;
- participating in the Stop TB Partnership Coordinating Board meeting in Jakarta, Indonesia, and meeting with the Vice-President of Indonesia.

**Implementation of the Stop TB Strategy**

A meeting was held in Paris between activists, former patients, chairs and members of the Working Groups, National TB control programme (NTP) managers and partners to discuss collaboration and implementation of the six components of the Stop TB Strategy.

- alignment of national plans with the Global Plan
- political commitment, with the need for sustained and/or increased resources to reach MDGs
- ensuring sustainability
- health system strengthening
- better coordination of the new strategy and of multiple partners.

“ High quality information tools are essential for effective advocacy and communication and the web site is a critical entry point. ”

**Keeping partners and the world informed**

High quality information tools are essential for effective advocacy and communication and the web site is a critical entry point. The Stop TB Partnership web site attracted 1.5 million visits in 2006, an increase of 93% over the previous year and the Global Plan to Stop TB, 2006–2015 document was downloaded over 150 000 times. The web site evolved in 2006 in its architecture, design, navigation and usability to improve access to information and news on TB and several sub-sites were added.

**Retooling – preparing for the introduction of new tools to combat TB**

An innovative pipeline of new drugs and vaccines is being developed through the New Tools Working Groups. In order to ensure the adoption and timely introduction of these tools as they become available. The Stop TB Coordinating Board established a task force on retooling to develop a strategy on implementing new tools in the field (see Box 5).

**Box 5: The Retooling Task Force**

Past experience in other disease areas has shown that there is often a significant delay between the availability of new tools at the global level and their eventual implementation at country level for disease control and prevention.

The framework document developed by the newly-established Retooling Task Force provides an overview of technical and operational considerations for retooling at global and national levels, identifies challenges, and proposes key steps for facilitating appropriate and timely implementation. The final draft document was endorsed by the Coordinating Board in November 2006.

The Retooling Task Force also developed its 2007 workplan which includes the development of a stakeholder engagement plan; detailed illustrative timelines for adoption and implementation of new diagnostics; monitoring and evaluation indicators; and pipeline updates for drugs, diagnostics and vaccines.





## BUILDING COMMITMENT

Advocacy, communication and social mobilization support national TB programmes and other initiatives to improve treatment adherence and combat stigma and discrimination, among other goals.

# Working Groups

### The Advocacy, Communication and Social Mobilization Working Group

In July 2006, Paul Sommerfeld from TB Alert, an NGO in the United Kingdom, was elected as Chair. The Working Group was restructured to align its objectives with those in the Global Plan, the WHO Stop TB Strategy, and the aims of the other working groups of the Stop TB Partnership.

### Global Advocacy Subgroup for resource mobilization

The Global Advocacy subgroup established three task forces to:

- improve media, events, and information products
- engage businesses
- establish liaison points with the existing G8 and EU Task Forces.

and three cross-cutting task forces to:

- build national partnerships
- improve patient-led national advocacy
- improve communication, resource generation and social mobilization for XDR-TB.

The following were some of the key activities of the Task Forces which initiated their operation in late 2006:

• **The Media and Events Task Force**

- developed a Common Messaging Platform to ensure resonance and consistency of messaging among partners and across several key conferences and events;
- helped to generate extensive coverage of XDR-TB and the need for new tools at the Union World Lung Conference in Paris in November 2006;
- developed the campaign theme for World TB Day 2007: 'TB Anywhere is TB Everywhere';
- supported the Panos Institute in training 20 journalists from 10 countries around the world on TB issues.

• **The Building National Partnership Task Force** held a workshop in November 2006 to discuss the preparation of a practical handbook on national partnership that will compile the different experiences and best practices across different national TB movements.

• **The G8 Group** drafted a consensus Stop TB Partnership statement for the St Petersburg G8 Communiqué and advocated effectively for its inclusion in the final document.

In collaboration with the Stop TB Secretariat, the subgroup raised resources in 2006 to implement global advocacy activities, implement the Call to Stop TB, and increase media visibility of TB. The main achievements were:

• Dr Kenneth Kaunda representing the Stop TB Partnership at the Special Summit of the African Union on HIV/AIDS, Tuberculosis and Malaria in May 2006. The summit resulted in a resolution to achieve accelerated action towards universal access to AIDS, tuberculosis and malaria services in Africa by 2010. This resolution was presented to the World Health Assembly by the African Union in May 2006.

• The United Kingdom Government responding to concern about the growing scale and impact of the TB epidemic

by establishing an All Party Parliamentary Group on Global Tuberculosis (APPG). The APPG will act as a forum for discussion and further strategic action to raise the profile of TB in the British parliament. Members of the ACSM Working Group and RESULTS UK form the secretariat of APPG.

• Identifying eight countries, sectors, and institutions as a first priority for accelerated advocacy activities in 2007–2008. They include: four oil-rich countries, and Italy, Japan, Norway, and Spain; investment pools including the private sector and regional development banks; and Rotary International. In addition work commenced in November 2006 on building political and financial commitment to the Global Plan to Stop TB 2006-2015 in European Union, Germany, the United Kingdom and the United States with support from the Bill and Melinda Gates Foundation, the Global Fund and the World Bank. This list will be amended in the light of results obtained.

**World TB Day**

Events were held around the theme of the day, "Actions for life: towards a world free of tuberculosis", to stress the importance of implementing the Global Plan to Stop TB, including:

• local events in countries calling for stronger support to TB control and the Global Plan with the participation of Stop TB Partnership representatives;

• the launch by WHO of the Global TB Control Report for which the Partnership provided strong support;

• broadcasting of special 12–15 min radio programmes in the European Region on how to prevent TB, and in sub-Saharan Africa and the Eastern Mediterranean Region on how to better implement prevention, diagnosis and treatment.

• mounting a Stop TB exhibition at WHO Headquarters in Geneva, Switzerland, with information, films and videos on

TB, the Global Plan to Stop TB, and the Global TB Control Report.

**ACSM at Country Level: translating country-level resources into action and results**

The main achievements of the subgroup were:

• helping applicants secure approximately US\$ 30 million in the sixth round of Global Fund grants to design, implement and monitor ACSM activities in 30 countries;

• securing funding for a new technical assistance mechanism from PEPFAR through USAID to improve absorptive capacity and to enhance performance of the ACSM component of the Global Fund grants. Linked with the ACSM subgroup, the TB Technical Assistance Mechanism (TBTEAM) will coordinate technical assistance to all Global Fund countries with ACSM activities, upon their request. The goal is to expand the number of countries (currently 19) that have multisectoral, participatory ACSM initiatives.

• organizing more than 10 ACSM technical assistance missions and training workshops to help countries in developing and implementing ACSM strategies and activities. This support was given by partners to Afghanistan, Indonesia, Iraq, Kenya, Myanmar, Nigeria, Pakistan and the Philippines. ACSM training and skill-building workshops were organized for countries in the WHO African, Eastern Mediterranean and Western Pacific Regions.

• advising more than 26 countries and 4 regional offices on the need to embrace various elements of the recommended best practices and strategies through the Stop TB Partnership's 10-year Strategic Framework for ACSM at country-level which generated synergies and creative thinking with respect to the evolution of the Stop TB Strategy. The Task Force on Community-Based TB Care incorporated elements of ACSM into its guidelines and contributed to a broader discussion within the Stop TB movement on the role of ACSM in TB control at the country-level.



“ In collaboration with the Stop TB Secretariat, the subgroup raised resources in 2006 to implement global advocacy activities, implement the Call to Stop TB, and increase media visibility of TB. ”



### The DOTS Expansion Working Group (DEWG)

A two-day event was held at the Thirty-seventh Union World Lung Conference in Paris, France, on the theme “From DOTS to the Stop TB Strategy: Building on Achievements for Future Planning”. The first day brought together representatives from the 22 high TB burden countries (HBCs) and Core Groups of the DOTS Expansion, TB/HIV and MDR-TB Working Groups; the second day was devoted to a symposium open to the TB community. The aims were to discuss major challenges and possible solutions to scaling-up TB control in the 22 HBCs in line with the Stop TB Strategy and the Global Plan, and to update the TB community on progress in TB control at country level and on the activities of the Working Groups of the Stop TB Partnership.

### DOTS expansion in countries

All WHO regions have initiated (and three have finalized) development of regional medium-term plans (with inputs from all DEWG partners) in line with the Stop TB strategy. TBTEAM provided technical assistance and support to the development of country strategic plans to ensure their compatibility with the Global Plan. The implementation of these plans is being monitored on an ongoing basis through in-country reviews and monitoring missions.

### Supporting countries in resource mobilization

TBTEAM, in coordination with the Secretariat of the Global Fund, held a TB proposal preparation workshop in Geneva, Switzerland, using the Stop TB Strategy Planning Frameworks, and supported 48 countries in the proposal development process for the sixth round. These efforts yielded the highest success rate for TB proposals (64% success and 71% of those supported by TBTEAM) and the highest success rate for any disease for all Global Fund rounds.

### Laboratory Strengthening Subgroup

A strategy for strengthening TB laboratories was launched in 2006 with the objective to improve access to quality-assured sputum smear microscopy, and to expand culture

“ International Standards for Tuberculosis Care (ISTC), a document aimed primarily at engaging private health-care providers in TB control, was launched worldwide. ”

and anti-TB drug susceptibility testing. A laboratory survey carried out in June 2006 in 75 countries (including 15 HBCs), showed that laboratory services were suboptimal due to insufficient infrastructure, funding, equipment and supplies, human resources, and implementation of quality assurance.

Technical assistance was provided to 31 countries in 2006. To increase the number of laboratory consultants, the first laboratory consultant training course took place in July 2006 and training packages and courses were developed to tackle some of the gaps in laboratory services. For example:

- a smear microscopy training package developed by CDC, WHO and partners
- a course on culture and anti-TB drug susceptibility testing
- training material on external quality assurance for sputum microscopy
- a laboratory management course for the directors of the national reference laboratories.

### Engaging all care providers - The Public-Private Mix (PPM) Subgroup

“International Standards for Tuberculosis Care (ISTC)”, a document aimed primarily at engaging private health-care providers in TB control, was launched worldwide on World TB Day. Ten HBCs have developed plans to use ISTC as an advocacy and training tool for PPM approaches.

The PPM Subgroup published “Engaging all health-care providers in TB control – guidance on implementing public-private mix approaches”. With assistance from the subgroup, countries have made significant progress; all 22 HBCs now have some PPM activity in place and 11 have started to scale up. The subgroup held its fourth meeting in Nairobi, Kenya, with a special focus on PPM in Africa, and highlighted the relevance of PPM in engaging diverse

care providers not only in TB control but also in TB/HIV collaborative activities and management of MDR-TB.

In 2006 a framework for incorporating PPM into Global Fund applications was developed, an advocacy brochure was produced, and PPM was incorporated into the revised recording and reporting system for TB. A comprehensive PPM training package was prepared and the first PPM consultant training workshop was organized in Geneva, Switzerland. PPM has also been integrated into the TB consultant training courses offered in Sondalo, Italy, and by the Japan Anti-TB Association.

### Prioritizing the needs of the poor and vulnerable - The Subgroup on TB and Poverty

The Subgroup on TB and Poverty:

- finalized an action plan on TB and Poverty which was approved by the Stop TB Coordinating Board;
- organized with KNCV a course on “TB and Poverty” at the Union World Lung Conference;
- entered into discussions with the New Diagnostics Working Group about the importance to the poor of access to one-stop diagnosis.

### Addressing TB among children - The Childhood TB Subgroup

The subgroup met with the joint DEWG, TB/HIV and DOTS-plus Working Groups and agreed on the need to promote implementation of the guidance for national TB programmes on managing childhood TB. This guidance includes the new policies on recording and reporting by age groups; the recommended dose of Ethambutol for children; mainstreaming research priorities as part of routine programme activities; and promoting child-friendly formulations of anti-TB drugs.



### The Working Group on MDR-TB

The occurrence of XDR-TB highlights the urgent need to focus on translating the Global Plan's strategic directions into effective operations at country level and to accelerate the development of new tools. In 2006 the management of MDR-TB (and XDR-TB) was confirmed as a critical component of TB control as set out in both the Global Plan and the Stop TB Strategy.

### Extensively drug resistant TB (XDR-TB)

The first global compilation of XDR-TB data by the US Centres for Disease Control and Prevention (CDC), WHO and 25 supranational TB reference laboratories (SRLs) indicated that resistance to second-line anti-TB drugs was present worldwide. In response to this international concern and the high mortality rates observed in an HIV-associated outbreak of XDR-TB in Tugela Ferry, KwaZulu-Natal Province, South Africa, an expert consultation was organized jointly by the South African Medical Research Council (SAMRC), WHO and CDC in Johannesburg, South Africa.

A WHO Global XDR-TB Task Force met in October 2006 and produced recommendations on key responses, which include strengthening basic TB control and proper management of MDR-TB. A web site on XDR-TB was set up and an MDR-TB and XDR-TB Response Plan developed (to be finalized early in 2007) aiming to mainstream the XDR-TB response into day-to-day TB control activities.

Several meetings were organized with South African Development Community (SADC) countries to better understand the magnitude and spread of XDR-TB and to ensure properly coordinated prevention and control activities. SADC countries agreed to develop MDR-TB and XDR-TB response plans, carry out rapid XDR-TB surveys among known and suspected MDR-TB cases, and consider future management of MDR-TB in collaboration with the Green Light Committee (GLC). Significant technical and financial assistance was provided by WHO, CDC, PIH and KNCV, supported by several donors including the

UK Department for International Development, the Italian Cooperation, Open Society Institute and USAID who together provided about US\$ 8 million.

### Regular drug resistance surveillance

In 2006 drug resistance surveillance coverage expanded by 10%, including impressive scale-up in China and India. Other countries that completed, have ongoing, or are planning drug resistance surveys in the near future include Armenia, Azerbaijan, Botswana, Democratic Republic of the Congo, Ethiopia, Georgia, Kyrgyzstan, Lesotho, Madagascar, Malawi, Mozambique, Namibia, Republic of Moldova, Rwanda, Senegal, Uganda, United Republic of Tanzania, Uzbekistan and Zimbabwe. Routine drug resistance surveys will now incorporate tests of susceptibility to second-line anti-TB drugs on all MDR-TB isolates collected.

### Quality-assured laboratory testing

A laboratory in the South-East Asia Region was added to the SRL network to assist at least four countries in future and funds have been raised to expand the network with an additional laboratory for the African Region. The annual meeting of the network was held in Paris, France, in November 2006.

It was noted that the Russian Federation has implemented a laboratory quality assurance system in over 30 regions.

### Management of MDR-TB patients

The new WHO guidelines for the programmatic management of drug-resistant TB were launched in May 2006. To improve the understanding of MDR-TB surveillance and control at country level, more than 100 key staff of national TB control programmes were trained at MDR-TB management workshops in four WHO Regions, and 25 MDR-TB consultants received training at the WHO Collaborating Centre for Research and Training in Management of MDR-TB, in Riga, Latvia. The consultants will be further exposed to the issues of MDR-TB control at country level by joining GLC missions in 2007.

At the fifth annual meeting of the Working Group the major bottlenecks to the global scale-up of MDR-TB management were discussed and an outline operational plan was drafted in line with the Global Plan. Three new subgroups, on research, advocacy and resource mobilization, and second-line drug management and procurement, were launched.

### Availability of second-line drugs

- During the year, 22 countries received deliveries of second-line anti-TB drugs for use in 25 MDR-TB Management Programmes that had been approved by the GLC. These deliveries reflected a total value of US\$ 3.69 million worth of second-line drugs - approximately 40% more than the value of deliveries made in 2005 (US\$ 2.64 million).

- Workshops were organized in China and the Russian Federation to assist local manufacturers to submit appropriate dossiers to the WHO prequalification project.

- UNITAID, an innovative financing mechanism for TB, HIV and malaria drugs led by Brazil, Chile, France, Norway and the United Kingdom, agreed to support the WHO prequalification project.

- The International Dispensary Association was re-selected through a competitive tender process for the supply of second-line anti-TB drugs to GLC-approved projects until the end of 2008.

### The Green Light Committee (GLC)

By December 2006, the GLC (for access to second-line TB drugs) had approved a total of 53 projects covering more than 25 000 MDR-TB patients in 42 countries (Table 3). During the year it approved 24 applications covering more than 12 000 patients with MDR-TB; double the number in 2005. However, despite this encouraging trend, worldwide less than 5% of patients with drug-resistant TB are currently covered, highlighting the need for countries to make urgent increased use of GLC services and plan for quality MDR-TB treatment.

In 2006 the GLC streamlined and strengthened its processes to respond to increasing demands from countries and to meet the targets in the Global Plan and the Stop TB Strategy. New instructions for applications to the GLC and the new guidelines for the programmatic management of drug-resistant TB, launched in 2006, provide a completely new foundation for scaling-up programmes for the sound management of drug-resistant

**Table 3: Countries supported by GLC in the treatment of MDR-TB patients**

Projects approved in 2006	Projects approved prior to 2006			Applications under review
Armenia	Azerbaijan	Jordan	Peru	China
Bangladesh	Bolivia	Kenya	Philippines	India
Belize	Costa Rica	Kyrgyzstan	Romania	Lesotho
Burkina Faso	Dominican Republic	Latvia	Republic of Moldova	Russian Federation
Cambodia	El Salvador	Lebanon	Russian Federation	Uganda
Democratic Republic of the Congo	Egypt	Lithuania	(12 oblasts)	Ukraine
Ecuador	Estonia	Malawi	Syrian Arab Republic	
Guinea	Georgia	Mexico	Timor-Leste	
Kazakhstan	Haiti	Mongolia	Tunisia	
Paraguay	Honduras	Nepal	Uzbekistan	
Rwanda	India	Nicaragua		

TB worldwide. The Secretariat for GLC's technical support and project approval is based in WHO and its drug supply support is merged with Global Drug Facility (GDF) in 2006.

As a step towards meeting the need to expand the management of drug-resistant TB globally, the GLC continued to build and strengthen partnerships with major funding mechanisms:

- At the thirteenth Global Fund board meeting it was decided that countries requesting funds for MDR-TB control must include a cost-sharing element for GLC services corresponding to a flat rate per grant per year not exceeding US\$ 50 000.
- USAID provided US\$ 2 million to support the costs of technical assistance and monitoring for Global Fund grant recipients with a MDR-TB objective.
- UNITAID agreed to provide US\$ 20 million for second-line anti-TB drugs to GLC-approved projects mainly in low-income countries.
- For the third consecutive year, Eli Lilly and Company provided funds to WHO (US\$ 678 000) for technical assistance to GLC-approved countries and training activities focused on Africa, South-East Asia, China, India and the Russian Federation.
- The Bill & Melinda Gates Foundation provided US\$ 850 000 to help sustain the GLC.

GLC membership was extended to KNCV, Hospital Muniz (Argentina) and World Care Council (representing the TB community).

### The TB/HIV Working Group Expanding collaborative TB/HIV activities

During 2006 the group continued to monitor and promote country-level implementation of collaborative TB/HIV activities and to develop a sound evidence base and policies to provide high-quality care for HIV-infected TB patients.

The updated list of TB/HIV priority countries includes 63; i.e. all those with an adult HIV prevalence  $\geq 1\%$ , and Brazil, China, India, Indonesia and Viet Nam, which all together carry 98% of the global burden of HIV-infected TB patients. Fifty-eight of the 63 priority countries provided data for the WHO annual Global TB Control Report. Of these 58, 50–60% had:

- appointed a TB/HIV focal point in the NTP,
- developed a formal procedure and a national plan for implementing TB/HIV activities,
- a policy of testing TB patients for HIV and for providing HIV care and treatment to those with TB, and
- a policy to provide CPT and ART to HIV-positive TB patients.

To improve recording and reporting of the implementation of collaborative TB/HIV activities, the Working Group, in coordination with other working groups and partners, revised TB recording and reporting formats to give due emphasis to HIV-related inputs.

### Diagnosis and treatment of TB in HIV-positive patients

- Case definitions and diagnostic algorithms were updated to expedite the diagnosis and treatment of TB in HIV-prevalent and resource-constrained settings. These recommendations, aimed at both TB and HIV control programmes, imply different approaches to management of TB in HIV-prevalent and non-prevalent settings.

- The TB component of the WHO Guidelines on ART was updated with new recommendations for the use of

Nevirapine and the definition of Immune Reconstitution Syndrome.

- A TB/HIV addendum for inclusion in the WHO Guidelines for the Prevention of Tuberculosis in Health-Care Facilities in Resource-Limited Settings was drafted by CDC, USAID, PEPFAR, the Union and WHO.

The Working Group also:

- participated actively in the response to the emergence of XDR-TB and established a subgroup on infection control with the agreement of the Stop TB Partnership Coordinating Board;
- ensured visibility for TB/HIV at the 2006 International AIDS Conference in Toronto, Canada through partnering with the International AIDS Society, WHO, UNAIDS, Treatment Action Group and the Forum for Collaborative HIV Research to highlight the need for TB prevention, diagnosis and treatment to be core functions of HIV prevention, treatment and care services;
- improved its communication by the publication of a regular newsletter, scientific publications in peer-reviewed scientific journals, and an updated web site.

### The Working Group on New TB Diagnostics Developing and evaluating a portfolio of new diagnostic tools

Significant progress has been made in advancing promising new products along the development pipeline including a new phage-based test for the detection of rifampicin-resistant *Mycobacterium tuberculosis*, and simplified nucleic acid amplification tests.

- Updates on the development of LED-based fluorescence microscopy systems and LAMP technology for TB diagnosis were presented at the Working Group meeting during the Union World Lung Conference in November 2006.

- Progress in developing a breath test for TB, and in a major TB antigen discovery programme, was reviewed.

- Evaluations of commercially-available serological antibody detection tests in the diagnosis of pulmonary and extra-pulmonary TB were reviewed; it was concluded that these tests perform poorly and have no role in TB diagnosis

- MGIT demonstration projects supported by FIND have been undertaken in some countries; results are expected to be available early 2008.

### Improving existing tools

Studies of sputum smear microscopy were undertaken to define ways to optimize this diagnostic tool and to provide a standard against which to judge new technologies. On the basis of the results, large multicentre studies were planned and diagnostic trial sites selected to determine:

- the optimum timing and composition of sputum specimen sets for efficient diagnosis of sputum smear-positive patients;
- the value of low-cost fluorescence microscopy systems for the diagnosis of sputum smear-positive patients;
- the value of sputum processing methods, such as bleach digestion, in improving sputum smear microscopy.

### Implementing new diagnostic tools

GDF proposes to include TB diagnostics in order to expand access to, and availability of, high-quality diagnostics in support of global DOTS expansion. UNITAID also agreed to consider supporting MDR-TB diagnostics.

“ The Working Group aims to continue to identify potential sites for clinical trials to ensure appropriate capacity for the clinical evaluation of new drug candidates... ”



### The Working Group on TB Drug Development

#### The drug development pipeline

In 2006 the Working Group initiated a web-based survey to track additions and updates to the global pipeline of TB drugs on a continuing basis. Progress is significant with seven drugs, an unprecedented number, currently in clinical development, paving the way for the introduction of the first new TB regimen for 40 years. In addition, six preclinical candidates and more than 30 discovery and basic translational research projects are in development.

The Global Alliance for TB Drug Development, the hosting agency of the Working Group, commissioned a study “Pathway to Patients”, which analyses the pricing, purchasing, procurement and distribution mechanisms for first- and second-line TB treatments in eight countries, and provides an estimate of the size of the global first-line TB drug market. The report will be released in May 2007.

The Working Group aims to continue to identify potential sites for clinical trials to ensure appropriate capacity for the clinical evaluation of new drug candidates for TB, and to establish a task force on XDR-TB to discuss recommendations for the TB drug development community.

#### Regulatory approval

The second Open Forum on “Regulatory Hurdles to TB Drug Development” in London, United Kingdom, aimed to increase representation from European and HBC regulators, and policy-makers, and from the communities infected/affected by the disease. The Working Group Secretariat organized the event in coordination with the Bill & Melinda Gates Foundation, the TB Alliance, and Treatment Action Group and plans to continue to facilitate dialogue on regulatory issues via the Open Forum series.

### The Working Group on New TB Vaccines

#### Keeping the vaccine pipeline filled

Two vaccines moved to clinical trial stage:

- The MVA-85A vaccine from Oxford University (United Kingdom). It is based on vaccinia virus modified to deliver a *M. tuberculosis* antigen and was the first of the new TB vaccine candidates to commence phase II clinical trials in the Western Cape region of South Africa in summer 2006. This vaccine has already undergone extensive clinical testing in different populations (including tuberculin-positive and HIV-positive individuals) and different highly-endemic situations (in the Gambia).

- Another vaccine candidate, based on an adenovirus vector expressing tuberculosis antigens, developed jointly by the Aeras Global TB Vaccine Foundation and Crucell Inc. of the Netherlands, entered an initial phase I clinical trial in October 2006.

Two development programmes focusing on recombinant BCG vaccines, at the Max-Planck-Institute for Infection Biology (Berlin, Germany) and the Aeras Global TB Vaccine Foundation, respectively, advanced in their preclinical development and are expected to enter clinical evaluation in 2007.

#### Capacity at new TB vaccine trial sites

The geographical scope of phase III trial sites has expanded beyond South Africa to Ethiopia, India and Uganda, through the coordinated efforts of the Aeras Global TB Vaccine Foundation, the European-Developing Country Clinical Trials Platform and the EU's TBVAC initiatives amongst others.

#### Availability of vaccine production capacity

Vaccine production capacity and scale-up received a major boost in 2006 by the establishment of a vaccine production plant for live bacterial vaccines and in particular BCG at the Aeras Global TB Vaccine Foundation's facility. This meets a critical need since the facilities for producing BCG (a live, infectious agent) are very limited, old, and often incompatible with modern vaccine production technologies.

#### An enabling infrastructure

In March 2006, Mr Michel Greco the new Chairperson of the Working Group established five task forces to:

- address definition and harmonization of laboratory and clinical parameters of TB vaccine research;
- reinforce clinical study sites capacity, especially in India and South Africa, to prepare for the future phase III trials;
- focus on strengthening discovery and translation research to keep the vaccine pipeline filled;
- study the economic aspects of TB vaccine development and introduction;
- provide a link with the overall ACSM activities of the Stop TB Partnership.



## TREATMENT FOR PEOPLE IN NEED

The best available ways to stop drug-resistant TB are to ensure that every person with TB has access to accurate diagnosis and effective treatment to cure and to stop the transmission of TB – two of the missions of the Stop TB Partnership.

# The Global Drug Facility

The Global Drug Facility (GDF) of the Stop TB Partnership approved access to 3.3 million life-saving anti-TB drug treatments in 2006. This meant approving 43 countries for new GDF grants and placing new drug orders worth US\$ 29 million for its grant recipients. In addition, 22 countries chose to procure anti-TB drugs through GDF using their own money or money from other donors. GDF placed orders worth US\$ 6.2 million of quality anti-TB drugs to these direct procurement customers.

During the year GDF brokered technical assistance missions to 59 countries by drug management and TB experts. Drawn from members of the Stop TB Partnership, mission teams monitor the use of anti-TB drugs supplied by GDF and work with national programmes to address bottlenecks and weaknesses in their supply chain, calculate their future drug needs, and develop a procurement plan.

Through workshops in Benin, France, and Kazakhstan, GDF provided crucial training to national and regional consultants on how to properly procure and manage anti-TB drugs. Such drug management workshops directly benefit TB control, but also teach skills that health-care workers can use when managing medicines and supplies for other health programmes.

In 2006, GDF received US\$ 44 million from its donors. Its operations were certified as ISO 9001:2000 compliant for “provision of quality-assured anti-TB drugs and related services to eligible national TB control programmes”. UNAID selected GDF as its programmatic partner to supply anti-TB drugs for children, and GDF expanded its product catalogue to include second-line anti-TB drugs (for the treatment of MDR-TB) through the merger of its procurement function with that of the GLC (see page 29).

Development of its state-of-the-art information system continued apace, allowing GDF to monitor its services to countries and report regularly on key indicators and progress via its public web site.



## PROGRESS AND CHALLENGES

Since 2000 the Partnership's income has grown at a compound rate of 43% per annum, but many challenges remain, above all, to help partners secure funds necessary for scaling up their TB control efforts.

# Resource mobilization & financial management

During 2006, efforts continued to shape a robust and effective policy dialogue with donors on the needs and priorities of the Stop TB Partnership. Closer relationships were developed with existing donors by providing regular progress reports on the performance of the Secretariat during the year. New donor commitments totalling US\$ 37.4 million were signed with the Bill & Melinda Gates Foundation, CIDA, the Governments of Norway, the Netherlands and USAID.

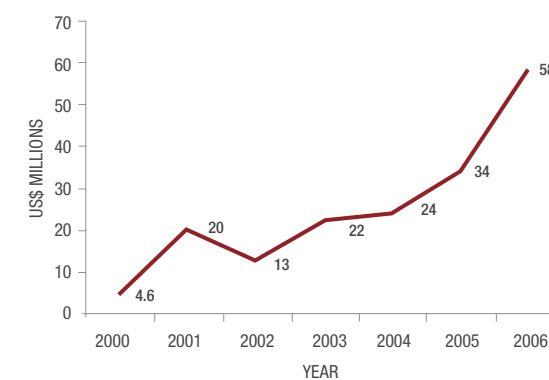
During 2006, the total income of the Partnership Secretariat was US\$ 58 million; a significant increase of 69% over 2005 (US\$ 34.4 million). Of the total income received in 2006, US\$ 54 million were channelled through the Stop TB Partnership Trust Fund. During the same period, the operating expenditure of the Secretariat was US\$ 52.9 million, resulting in a surplus of US\$ 4 million after reserves. It should be noted that since 2000 the Partnership's income of US\$4.6 million in that year has grown at a compound rate of 43.6% per annum to US\$ 58 million in 2006 (Figure 3). Contributions in-kind increased to US\$ 3.74 million due, in part, to donations by Novartis of anti-TB drugs for the United Republic of Tanzania and Sri Lanka to the value of US\$ 3.2 million.

Steps were taken to put in place better controls to reduce financial risk. As required by the financial policy approved by the Stop TB Coordinating Board, reserves (up to 10% of income) should be built up. A first step was taken in

this direction with US\$ 1 million placed in reserve. Interest totalling US\$ 1.2 million, covering the period 2005 and 2006, was notified and credited to the Stop TB Partnership Trust Fund at WHO in January 2007. 2006 was the first year of the implementation of the workplan for the biennium 2006–2007. The implementation rate was 58% of the approved workplan. Summary statements of income and expenditures for the Partnership and GDF are given in Annexes I and II, respectively.

Looking forward, one of the challenges for the Stop TB Partnership will be to help partners to secure funds for implementing their TB control activities, and to coordinate potentially conflicting mandates and demands of partners as they gear-up to deliver the Global Plan.

**Figure 3: Total income from year 2000 to 2006**



## Annex I: Stop TB Partnership Secretariat

### Summary statement of income and expenditure for the year ending 31 December 2006

(All figures in US\$'000)

INCOME	2005	2006
<b>Voluntary contributions in cash</b>		
Governments & their agencies	29 859	50 268
Multilateral organizations	700	700
Foundations and others	470	2 059
Interest	0	1 280
<b>Subtotal</b>	<b>31 029</b>	<b>54 307</b>
<b>Voluntary contributions in-kind</b>		
Governments	169	13
Multilateral organizations and foundations	547	504
In-kind contribution for drugs (Novartis)	2 605	3 226
<b>Subtotal</b>	<b>3 321</b>	<b>3 743</b>
<b>TOTAL INCOME</b>	<b>34 350</b>	<b>58 050</b>

EXPENDITURE	2005	2006
Partnership	3 211	5 791
Advocacy, communication and social mobilisation	929	1 093
Global Drug Facility	31 347	43 346
General management and administration	1 173	2 740
<b>Total expenditure</b>	<b>36 660</b>	<b>52 970</b>
Transferred to reserves	0	1,000
<b>SURPLUS / (DEFICIT) of income over expenditure after transfer to / from reserves</b>	<b>(2 310)</b>	<b>4 080<sup>2</sup></b>

<sup>2</sup> This comprises US\$ 1 643 received in December 2006 which could not be obligated in that year. It also includes US\$ 2 437 needed for planned activities for the first quarter of 2007. Deficit from 2005 was covered by surplus brought forward from 2004.

## Annex II: Global Drug Facility

### Summary statement of income, contributions received for direct procurement and expenditure for the year ending 31 December 2006

(All figures in US\$'000)

INCOME	2005	2006
Government and their agencies - specified	26 085	40 723
In kind contribution for drugs from Novartis	2 605	3 226
Contributions for direct procurement	13 433	6 165
Other income	188	125
<b>TOTAL INCOME</b>	<b>42 311</b>	<b>50 239</b>

EXPENDITURE	2005	2006
Grant procurement for anti-TB drugs	28 367	41 344
Direct procurements	13 433	6 165
Quality assurance and prequalification	123	84
Technical assistance, monitoring and salaries	1 649	1 875
Advocacy and communication	57	43
Indirect costs	1 151	1 366
<b>Total expenditure</b>	<b>44 780</b>	<b>50 877</b>
<b>SURPLUS / (DEFICIT) of income over expenditure</b>	<b>(2 469)</b>	<b>(638)</b>

The Stop TB Partnership  
**ANNUAL REPORT 2006**

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