Challenge TB East Africa Region, Stakeholders' Meeting - July 29th – 31st, 2015, Nairobi, Kenya

Participants:

1. USAID Kenya and EA Region: Barbara Hughes, Dr. Subroto Mukherjee, Wairimu Gakuo, Dan K Koros and Maurice Maina
2. IOM: Miriti Damaris, Michela Martini, Paula Pace and Abdikadir Abdow
3. MSF: Jennifer Engul and Stephen Wangde
4. World Vision: Vianney Rusagara
5. NTP Kenya: Kamene Kimenye
6. CoE Rwanda: Francine Birungi
7. NTP Rwanda: Patrick Migambi
8. FHI 360: Dorothy Muroki
9. ECSA: Stephen Muleshe and Ann Masese
10. SNRL: Musisi Kenneth
11. Core Polio Group: Mercy Lutukai, Bal Ram Bhui
12. UNICEF: Rustam Haydarov
13. KNCV: Victor Ombeka, Mischa Heeger and Millicent Ngicho

Purpose of Meeting

The Challenge TB East Africa regional meeting brought together all stakeholders in the region to discuss cross-border issues, referral systems, streamlined capacity building on TB, the role of Ugandan supra-national reference laboratory and the further development of the Rwandan Center of Excellence.

Introduction

KNCV Tuberculosis Foundation recently began implementing the new five year USAID funded Challenge TB project as the prime partner of an international coalition. Over the next five years USAID will invest US$525 million through this project, to accelerate the global fight against tuberculosis (TB). The coalition consists of nine organizations: American Thoracic Society (ATS), FHI 360, International Union Against Tuberculosis (KNCV) and Lung Disease (The Union), Japan Anti-Tuberculosis Association (JATA), KNCV Tuberculosis Foundation, Management Sciences for Health (MSH), World Health Organization (WHO), PATH and Interactive Research and Development (IRD). Under the Challenge TB project the East Africa Regional Program is a nine month program funded by USAID East Africa, that focuses its activities in six priority countries in the region: Ethiopia, Kenya, Rwanda, Somalia, Tanzania and Uganda and covers activities that are beyond individual countries.

Global burden of multidrug-resistant TB tuberculosis (MDR-TB)

Drug resistant TB is a major public health problem that threatens progress made in TB care and control worldwide. Drug resistance arises through the improper use of antibiotics in chemotherapy of drug-susceptible TB patients, resulting from incorrect treatment regimens and the failure to ensure that patients complete the whole course of treatment. Essentially, drug resistance arises in areas with weak TB control programs. A patient who develops active TB disease with a drug-resistant TB strain can transmit this form of TB to other individuals
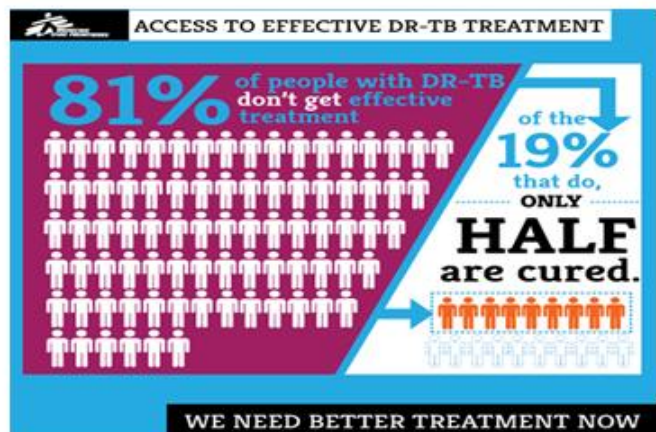
MDR-TB in East African Region

With frequent cross-border movement, the diagnosis and treatment of TB and MDR-TB remains a multinational problem that requires a multinational response. This means a strong and effective TB program with the capability to manage and prevent TB across the bordering countries, needs to be developed. Solutions must address the need for long treatment durations and take into account the complexities of TB control in mobile populations.

Regional implications of TB in Somalia

The challenge of TB in Somalia has implications beyond the country's borders. Currently over 400,000 Somalis reside in Kenyan refugee camps, and there are more living in the urban areas of Kenya. About 250,000 Somali refugees are in Ethiopia, and a similar number are in Yemen. Additionally, Somali refugees are relocated to many countries around the world. With ongoing MDR-TB transmission, refugees can become latently infected with MDR-TB and are then at risk of developing MDR-TB later in life, which can initiate new transmission cycles in their new countries of residence.

Geographical focus of the Challenge TB East Africa regional project

This project covers the USAID East Africa (EA) region and East, Central, Southern Africa Health Community (ECSA-HC) member states (East, South, Central and Horn of Africa region), though the focus is in 6 countries; Ethiopia, Kenya, Rwanda, Somalia, Tanzania and Uganda.

**TB CARE I (2010-2014) achievements and challenges**

The main objective of the USAID funded TB CARE I project was to put MDR-TB (PMDT) higher on the regional agenda, with the aim of gaining the commitment of health ministers at a time when most of the member states were not managing drug resistant TB.

ECSA/TB CARE I Project Main Achievements:

1. Development of Policies, Strategies & Plans
   - Integrated Infectious Diseases strategic plan, 2013-2018
   - Launched in February 2013 during the ECSA 58th HMC
   - Strategy on Cross-border and Regional Programming in TB prevention and Control Management
   - Prototype Competency based Nursing Curriculum outline for TB/MDRTB
   - Policy on management of M/XDR TB failures in the region

2. PMDT Country missions to eight out of the nine ECSA MS's with the objectives of:

   - Assessing implementation of the ECSA HMC Resolutions on TB/MDR-TB
   - Documentation of best/promising practices and lessons learnt in implementation of PMDT
   - Identify gaps and challenges in PMDT implementation

3. Knowledge sharing platforms:

   - TB Experts' Committee meetings for dissemination of TB updates, discuss policy issues and contribute to the Directors Joint Consultative Committee (DJCC) recommendations
   - TB Experts Meeting on Cross Border & Regional Programming in TB Control Participation in 19th Union Conference for African Region in Kigali, Rwanda

4. Capacity Building of ECSA Secretariat in TB/MDR-TB Issues:

   - The Union, International Tuberculosis Course in Arusha 2012
   - PMDT management, Centre of Excellence (CoE), Rwanda, 2013
   - The WHO training course "Towards the WHO post-2015 global TB control and elimination strategy: skills for managers and consultants" Cepina Italy, 2014

ECSA/TB CARE I Project Challenges:

- Harmonization of cross border & Regional Programming
- Inadequate domestic funding for cross border TB activities by National TB Programs (NTPs)
- Lack of human resources
- Lack of MDR-TB management skills
- Co-ordination of existing regional TB initiatives to avoid duplication
- Little TB/MDR-TB operations research/implementation in the region to inform policy
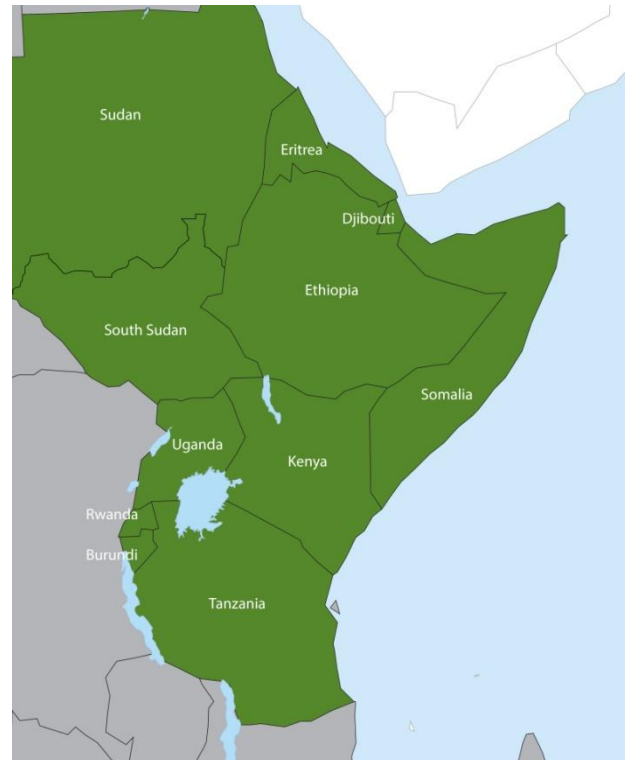
I.   Challenge TB aims and objectives in EA region

Challenge TB's three main objectives in the EA Region are:
1. Improved access to quality patient-centered care for TB, TB/HIV and MDR-TB services
2. Preventing of transmission and disease progression
3. Strengthening TB platforms

The proposed technical focus areas for the Challenge TB Regional project are:
*   Cross-border control to promote cross-country collaboration and coordination for improved TB control and surveillance across national borders;
*   Supporting National TB Reference Laboratories to address diagnostic capacity in key and vulnerable populations;
*   Strengthening PMDT to improve: access to second line TB drugs including new drugs and shorter regimens;
*   Building capacity on Childhood TB by establishing network for sharing and learning and incorporation of it into continuing education on TB and Maternal and Child Health;
*   Creating a regional training corridor by linking these institutions and earmarking them for specific trainings in TB.

Intended outcomes of EA Regional Stakeholders Meeting – Barbara Hughes (USAID Kenya)

The region faces various health problems ranging from the influx of refugees and mobile populations to conflicts across the bordering countries in the region. The region has one of the highest numbers of mobile populations because of past conflicts, which means it is hard to manage and reach people on TB treatment.

The Challenge TB project is building on the previous TB CAP and TB CARE I projects by:

1. Promoting cross-country collaboration and coordination for improved TB control and surveillance across national borders
2.   Supporting National TB Reference Laboratories to address diagnostic capacity in key and vulnerable populations
3. Strengthening PMDT to improve access to second line TB drugs (including new drugs and shorter regimens and M/XDR-TB case holding) and palliative care
4. Supporting capacity building for improved TB Management.
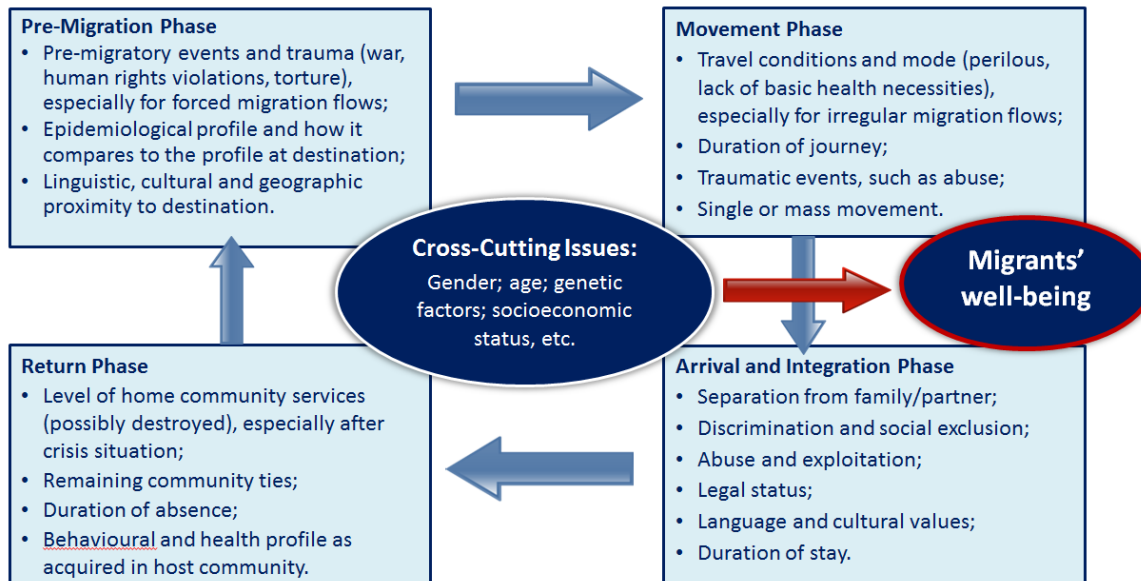

Discussion:
Strengthening PMDT in the region and how to harmonize introduction of palliative care and new drug containing regimens in the region.
How to improve country coordination and medicines exchange through a regional dashboard.

Presentation from International Organization for Migration – Paula Pace (IOM)

International Organization for Migration (IOM) currently manages four registered TB DOT centers with the NTP, which are located in the Eastleigh and Gigiri areas of Nairobi and the Kakuma and Dadaab refugee camps. IOM's clinic in Eastleigh provides free, non-discriminatory and comprehensive health care to both urban migrants (the majority of whom are from Somalia) and the host community.

Factors affecting health during the migration process:

Discussion:

1. How to work together in order to increase the number of patients receiving treatment for TB.
2. Patients need to be followed up after treatment to ensure effective treatment.
3. There is a need for research that looks into social determinants of health among mobile populations. Status of the public health services: The assumptions are that migrants are all in the camps and thus make it difficult for the migrants to access the public services.
4. Contact tracing of the TB patients; Reintegration of the patients back to the community.
5. There is ongoing discussion on return packages (e.g. medication) for TB patients.

Presentation from National Leprosy and Lung Disease Program Kenya - Dr. Kamene Kimenye Marita

Most Somali migrants go to Kenya because there are few treatment facilities in their own country. The map shows the migration movement within the EA region.

Needs:
1. A platform with the relevant stakeholders to manage TB related issues should be established.
2. The prevention TB infection for those who are taking care of TB patients remains a challenge.
3. Tackling stigma around TB patients in the community.
4. More funding/space for long patient stays in hospital (Treatment duration is 20 months).
5. The government needs to supply sufficient food to meet the nutritional requirements of TB patients (Strategies currently being pursued are to see if the counties can provide nutritional food to the patients in the camps).
6. There is the big problem of nomadic population movement with no access to TB care.
7. Identification rates for TB cases among the nomadic populations are extremely limited.
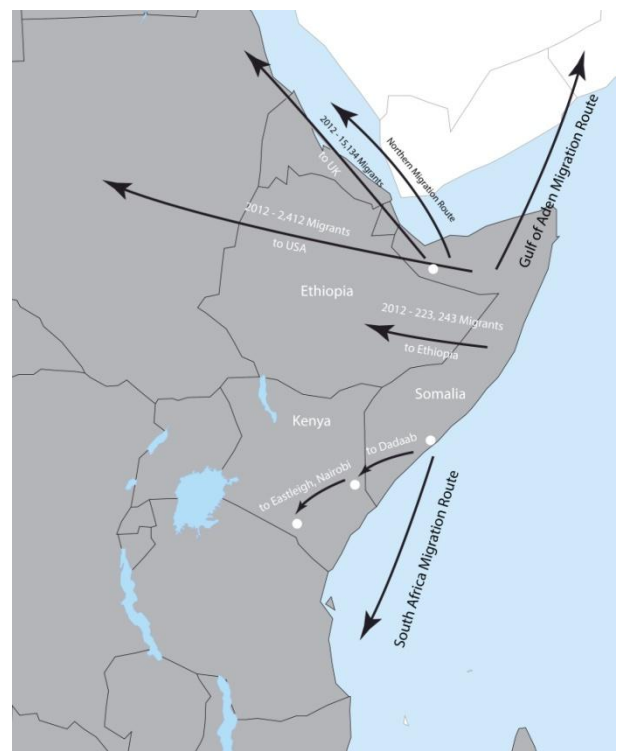
Somalia TB Program Update - Presentation from World Vision Somalia - Dr. Vianney Rusagara

World Vision supports the MDR-TB Management Center in Hargeisa which started in September 2013 and the Qatar Red Crescent is supporting TB treatment in Puntland. There is currently good coordination in the referral systems and testing centers, but culture tests are currently being sent to Nairobi and TB detection/coverage is inadequate. Distribution of treatment and testing supplies is a major challenge especially where and when there are conflicts.

Currently there are 66 facilities serving 12 million people, 176 people have been diagnosed with MDR-TB and are on treatment.

The challenges faced in setting up TB treatment center are that there is no capacity to set up the TB treatment centers by Somalia government. Certain areas (e.g. South-central Somalia) are very difficult to access because of security related issues.


Somalia TB Case Notification: 2010 - 2014
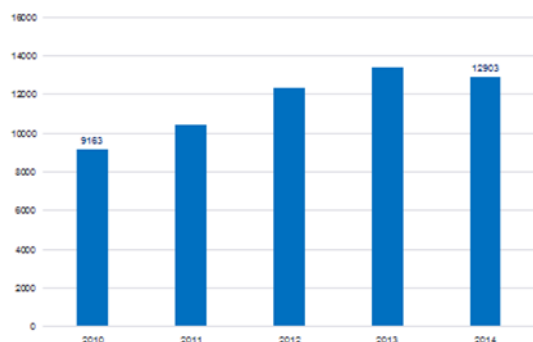
Somalia TB Data

- Prevalence: 584/100,000
- Incidence: 285/100,000
- Annual new TB cases: 30,000
- Multi Drug Resistant TB:
  - 5.2% of new cases
  - 40.7% of retreatment cases
  - Total: 3,000 annually (10.1%)
    (2014: New cases - 12,903) [MDR TB 1,303]
- TB/HIV co-infection: 8.3%

Challenges

- Inadequate coverage of TB services
  - Case notification 37% of incident case (2014)
  - 52 TBMUs required
- Population movement
  - Nomadic lifestyle
  - Internal displacement
  - Cross border migration
- Limited MDR TB services (Diagnosis and Treatment)
  -176 MDR TB cases detected cases representing 14%
- Distribution of supplies
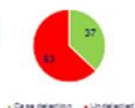
Discussion

Government TB funding is limited and there are currently no other sources to complement the existing funds.

Drugs are often shared among the patients with TB symptoms due to insufficient drug supplies.

There are no TB healthcare policies in place at health care facilities and the supervisory capacity of health services is minimal, especially in South Somalia.

Presentation MSF Nairobi - Jennifer Engul

According to the national epidemiology of MDR-TB report 2013, 291 DR-TB cases were notified in Kenya, of which 254 were MDR-TB, and the TB/HIV co-infection rate was 25% among the MDR-TB patients. The MSF clinic receives many Somali migrants who have travelled long distances to Nairobi in order to access better health care services. There are currently 32 MDR-TB patients, of whom 17 are Somali.

MSF Clinic Green House

Drug-resistant
Tuberculosis cohort

32 DR-TB patients in Green House
- **30 MDR-TB** (Multidrug-resistant (MDR): resistant to at least INH and RIF)
- **1 XDR-TB** (Extensively drug-resistant (XDR): MDR-TB plus resistance to a fluorochinolone and at least one of three injectables (Amk, Km, Cm))
- **1 pre-XDR-TB** (MDR-TB plus resistance to a fluorochinolone)

The clinic faces several challenges:
- Language (translation needed)
- Cultural challenges (e.g. family planning, fasting)
- Contact screening (most contacts are in Somalia)
- Follow up after treatment (most patients move back to Somalia)
- Extensive disease (due to treatment delays)
- A lack of treatment supporters (family or friends are in Somalia)
- No refugee status (persecuted by the police)
- Poor living conditions

Discussion

1. Contact tracing/screening needs to be undertaken
2. There is no referral systems for the follow-up of patients who return to Somalia
3. There is no way to disaggregate TB data for both Somalia and Kenya
4. MSF is only reporting to the Kenyan NTP and not to the Somalia NTP, so there is need for the NTPs to agree on how to capture the data for TB patients in the two countries
5. There is a need for non-interrupted treatment provision for patients who move between Kenya and Somalia.

FHI 360 presentation on the Regional Outreach Addressing AIDS through Development Strategies (ROADS) - Dorothy Muroki

The ROADS objectives:

1. Extend HIV and broader health services to underserved, most-at-risk mobile and community populations along transport corridors and waterways in East, Central and Southern Africa
2. Build the capacity of indigenous partners to design, implement and manage programming of their own design over the long term
3. Identify, test and diffuse innovations throughout sub-Saharan Africa.

The ROADS and TB Screening and Treatment project focuses on the following:

- HIV-TB Integration in Health Facilities
- TB Community Outreach
- HIV-TB Integration in Drop-in centers

TB Community Outreach

TB Community Outreach is a tool which has been developed and validated in Kinshasa, Democratic Republic of Congo (DRC) by Le Programme National de Lutte contre le Sida (PNLS) with the participation of implementing partners including international organizations in the context of strategies to address TB. It was disseminated by PNLS which directed its use at community- and institutional levels for TB screening. It is also used by other USAID partners such as Provic.

In Katanga Province, DRC, health services, including TB services, are often far from the people who need them or they are overstretched. To extend TB education, screening and referral, FHI 360/ROADS integrated TB into mobile outreach HIV Testing and Counseling (HTC) services. ROADS, alongside other implementing partners designed a TB screening tool administered to HTC clients where symptomatic clients are referred for confirmatory testing. From October 2014-June 2015 HTC sites identified 97 HIV-positive clients as TB symptomatic and linked them with TB services.

HIV-TB integration in Drop in centers- Zambia

TB case detection is integrated into HTC at all drop-in centers. All clients tested for HIV are also screened for TB, using an MoH/WHO screening tool. Those with symptoms are referred to nearest health center or hospital for confirmatory testing.

In Livingstone (a city in southern Zambia), the program worked with the Zambian AIDS Related TB Project (ZAMBART) to improve case detection. ZAMBART supplied the program with sputum bottles and collected containers with sputum from clients for off-site laboratory tests. The program referred clients with positive sputum tests or in need of further investigation to the Maramba Clinic TB diagnosis center.

In Kapiri Mposhi FHI 360/TB CARE I trained ROADS peer educators in symptom recognition and referral.

Lessons, challenges and opportunities in the implementation of the ROADS project

Lessons: Early case detection is possible when TB screening is integrated in HTC. Many people with a cough delay diagnosis because they do not realize that they may have TB.

Challenges: Distance and availability of TB screening services; offering integrated services was challenging due to low numbers of staff; patient follow-up is difficult because the system of capturing data is paper-based.

Clients may need to walk for more than eight kilometers to the ROADS centers for diagnosis and it takes one to two weeks to receive their results. Some who submitted sputum at the ROADS facility in Livingstone did not return for sputum results.

Opportunities: Trained personnel such as peer educators/peer promoters providing HIV prevention messages can be trained to provide TB-related information and referral. Community approaches developed by ROADS for HIV are also relevant for TB.

Strengthening support at community level is crucial in generating proper TB services.

Results

- Increased access to and uptake of integrated health and HIV/AIDS services at strategic cross-border sites and a select few regionally recognized HIV transmission "hotspots" along the eastern, central and southern transport corridors
- Alternative health-financing models identified, implemented, and tested to strengthen the long-term sustainability of networked health and HIV/AIDS service delivery
- Strengthened leadership and governance by intergovernmental institutions to improve the health of mobile and vulnerable populations.

TB Burden: Busia County, Kenya

Busia border has the highest TB defaulter rates in Busia county, current health care systems on the border between Kenya and Uganda are stretched and there are limited data or documentation on cross-border TB patients.

TB Burden: Busia County, Kenya

ALL TB CASES (ANNUAL)	1,500
CHILDREN	12%
MDR	3-4 cases per year Currently 4 are on treatment
TB/HIV CONJECTION	50%
HIV TESTING	98%
ART UPTAKE	97%

USAID
FROM THE AMERICAN PEOPLE

PEPFAR

fhi 360
THE SCIENCE OF IMPROVING LIVES

In April 2015, FHI 360/CB-HIPP met with the Busia County TB/Leprosy Deputy Coordinator to discuss TB and related program to be supported through CB-HIPP. The coordinator reporting challenges in addressing TB and the importance of strong cross-border partnerships to ensure positive TB outcomes among clients in these unique geographic areas.

Presentation on Reaching Mobile Population in the Horn of Africa with Polio & Routine Immunization Services project - Rustam Haydarow (UNICEF)

There are high level of migration across the East and Horn of Africa, because of socio cultural conflicts and economic needs . Therefore innovative approaches to target pastoralist and nomadic communities are critical to ending polio. Ethiopia mapping results identified 1620 new pastoralist settlements, up from the 240 previously recorded.

Puntland: Leveraging FAO Partnerships with Pastoralists

- Use the existing and trustworthy relationship between the Animal Vaccination Programme and over 2,000 pastoralist clan groups to reach nomadic populations
- Trust is the Key: Communication Protocols for Clan Elders developed/implemented by District Social Mobilization Coordinators /MoH staff
- Integrated Services & Health Education (polio, measles, Vit A, ORS): Reached over 26,000 pastoralist parents with education sessions.

Challenges in Scaling Up

- Reaching pastoral communities is much more resource and time consuming than reaching traditional populations
- Reaching pastoralist communities sustained social mobilization workforce and higher costs

- Monitoring and evaluating the outcomes of the engagement with pastoralists is an issue
- Health myths are very common and prevention is quite weak among the pastoralist communities as they are normally not easily reached with the established health facilities.

Opportunities for TB Programs

The 360 vaccination points, transit points and established social mobilization networks can also be utilized by the TB program and existing programs can be linked to share knowledge and achievements.

East Africa Cross Border Initiative for Polio Eradication in Horn of Africa - Bal Ram Bhui of the CORE Group Polio Project (CGPP)

CGPP is global project funded by USAID to support polio eradication world-wide by working with Ministries of Health, WHO, UNICEF, CDC Rotary and all national and local NGOs. CGPP currently works in Kenya, Somalia, Ethiopia, South Sudan, Nigeria, Angola and India.

Cross Border Initiative for Polio Eradication in HoA

Objectives

- Support border county health office to plan, implement, monitor and evaluate polio eradication strategies in its border communities, border crossing points and transit hubs

- Improve cross border collaboration between health and administrative authority of border regions for cross border polio eradication

- Improve communication between border counties, sub counties and health facilities.

Achievements

- Cross border meetings between respective border country counties held in Turkana (Kenya, South Sudan, Uganda), Marsabit (Kenya and Ethiopia), Wajir and Garissa.
- Advocacy on need to protect one's own borders and the necessity to collaborate with other stakeholders and implementing partners; security personnel etc.
- Cross border Initiative operation manual developed
- Border health micro planning in Turkana, Marsabit, Wajir, Garissa
- Use of micro planning to improve operation and social mobilization for cross border population for July 2015, SIA

Discussion

1. The idea is to work with the already existing health systems in the region, non-health partners, health committees, border countries NGOs and cross border health committees.
2. How to utilize already existing programs.
3. Look into ways to tap into what already exists on the ground among other organizations.
4. What will happen to the huge resources and facilities from the polio projects?

Stakeholder Meeting Outcomes

The following are the main outcomes derived from the input and discussions over the course of the stakeholders meeting:

- Establish a regional coordination platform
- NTP Kenya to take the lead because all the movements go through Kenya
- There is need for a structuralized forum for TB coordination
- Work with companies that attract migrants and see how they can be part of the platform
- Work at different levels i.e. the donor, government and community so that the coordination of the platform is streamlined
- Have internal programming of coordination committee for TB
- Challenge TB to formalize the existence of the coordination committee
- Harmonization of the committee to really communicate the TB
- TB experts committee to convene meetings annually
- Have a more broader experts committee
- Concrete communication tools among the
- Dashboard Approach: Challenge TB to establish dashboard so that all the partners can have access to the data and share with each other.
- WHO to oversee the platform
- Draw up a MoU among the partners
- NTP to find out what the cross-border counties are doing on polio and TB
- Use the already existing resources/structures for polio to implement TB projects
- Have referral mechanisms regionally or intra-country for patients
- Referral tools within the countries are being collected through ECSA

Field visit – MSF TB Clinic

A visit was made to MSF TB clinics in Eastleigh Nairobi where the participants met with both MDR-TB patients and the healthcare service providers.

The above pictures were taken at MSF clinic with participants, health care service providers and migrant MDR-TB patients from Somalia. The clinic was an exploratory field visit for the participants to share experiences from different countries in the care and treatment of MDR-TB patients.

Clinic Green House

- Screens and supports HIV/TB co-infected patients
- Runs full TB programs, the clinic focuses only on DR-TB program.
- 51 MDR-TB patients, every month the patients are discharged
- There is a major challenge with infection control and intensive case finding
- Receives 220 new cases per month in Mathare and Eastleigh
- Deals with a population of 2.1million, and is the only medical NGO in the area of Eastland, Nairobi.
- Many MDR-TB patients come from Somalia.

Clinic Lavender House

- Lavender house clinic supports gender based violence patients
- More than 50% of the women atttending the clinic have been raped.

Year 1 Planned Activities in the region - Dr. Stephen Muleshe

ECSA:
A.   Cross-Border and Regional Programming in TB Control
- Provide a platform for regional cooperation; this will enable countries to talk to each other:
    o   Develop a structure for the platform
    o   Develop TORs for the platform
    o   Communicate with the key players
    o   Convene the key players to a common platform
    o   Operationalize the platform
- Develop MoU's with non ECSA Member States
- Establish Demonstration Sites on Cross border, X/MDR-TB failures and inter country referral mechanisms; link these sites with all NTPs

B.   Training Corridor
1.   Create a secretariat for training through ECSA-HC:
    - Map training institutions in the regions offering TB training
    - Dedicate specific tasks for all institutions mapped
    - Develop ToR for the training institutions
    - Communicate with countries on all trainings in the region
    - Convene a workshop to build consensus on the training corridor and advocate for a resolution on the same.
2.   Operationalize the trainings:
    - Registration of courses
    - Deliver the courses

C.   Nursing Curriculum
- Identify one demonstration country; pilot the curriculum in one nursing institution
- Advocacy for other countries to take up the curriculum; bring out the component of TB programming as a selling point for the curriculum

D.   Dashboard for TB Drugs and Commodity Management (Led by MSH)
- Advocate for countries to use the dashboard

Center of Excellence Rwanda - Francine Birungi

The CoE needs to be more of a regional institution to be able to reach a wider population. The institution needs need a legal entity for its operations to be recognized and accredited by other institutions. The courses offered within CoE need recognition, accreditation and formal certification. The institution need to develop a logo as a form of recognition and identity. For the institution to be able to market its services widely, a business development plan would be ideal to share with other institutions for resources and capacity building. The institution must create a strong marketing strategy to be able to sell as many courses to payer candidates in the region as possible.

Supra-National Reference Laboratory - Kenneth Musisi

What role will the SNRL will play in the implementation of the Challenge TB EA Region Program?:
1.   Support the designing of a diagnostic referral system
2.   Create networks of laboratory systems; link this with the referral system
3.   Develop a training curriculum for laboratory courses
4.   Conduct trainings; link the SNRL with a training institution for accreditation purposes.

What is the SNRL's role in Challenge TB?
Strengthen regional network to for example MSF; training laboratory technicians from other institutions; Strengthening the Nairobi NTRL. The SNRL could play a big role in an international cross-country referral system. A major component in here is in diagnostics. The referral system should be a whole system of communication lines.

Discussion – Dr. Subroto Mukherjee

Discussions on the final day of the workshop were facilitated by Dr Subroto. He emphasized how we should share our resources and make use of each other's infrastructure during the implementation of the Challenge TB project.

Challenge TB is looking for opportunities where we can work with the partners who were present in the stakeholders meeting. The Challenge TB project is not going to reinvent the wheel, but utilize the resources from previous programs such as polio. Challenge TB works closely with the NTPs in this region to ensure a common understanding towards effective reduction of cross border TB.

The main focus area of Challenge TB project during the implementation period of the EA region program:
- Establish demonstration sites across the border. Not only showing how effective it is, but really operationalize and scale up (also by other partners).
- Establish cross-country referral system, work with one language (although keep the local language, but mention English as well), use codes for regimen/ duration etc. MSF has experience in this.
- Establishment of Horn of Africa coordination mechanism. IOM has a WHO person on board.

Outcomes of the Meeting

The meeting gave an insight on what's already going on at grass root level, which partners are already working in which areas and at what capacity, and finally what resources are needed to build on the already existing strategies. The Challenge TB team was able to get an overview of which areas would need focus during the Year 2 planning and development process. Below are some of specific outcomes of the meeting per partner institution/organization:

The key points from the meeting were:
1. Support the design of a diagnostic referral system.
2. Support the creation of a referral laboratory network system.
3. Provide support to the trainings of the CoE in development of curricula and conducting trainings
4. What is role of diagnostics? Challenge TB is not providing financially support, but continues to provide support with technical capacity.

Projections for APA 2 planning – Dr. Victor Ombeka and Dr. Subroto Mukherjee
1. Establish demonstration sites to implement the cross border interventions:
   a. Establish cross-border joint planning tool to cover screening, diagnosis, treatment, follow up, contact tracing, referral and sharing reports
   b. Conduct cross-border joint meetings among selected countries
2. Establish demonstration sites in selected countries to introduce inter- country referral system:
   a. Through consensus with key stakeholders and NTPs identify the demonstration countries-Link to regional coordination committee
   b. Develop scope of work documents for the potential partners to work in the demonstration countries-Depends on an additional country
3. Establish one demonstration site to implement the MDR/XDR-TB failure management approaches:
   a. Conduct a regular stakeholders meeting and dissemination workshop
   b. Promote the site as learning site for the countries in the region
   c. Get accreditation from WHO
4. Establish East and Horn of Africa regional TB coordination committee
5. Establish Training Corridor in the EA region for TB and MDR/XDR-TB training

a. Create a pool of experts in the region and collate available trainings into a unified training curriculum/schedule
b. Provide scope for further enrichment of the resources to reach international standards
c. Progress to get the training corridor and the institutions in it accredited by WHO.

Meeting Closure

Ms Wairimu Gakuo- USAID EA-Deputy Office Director closed the three day stakeholders by stating how committed USAID EA and the Horn of Africa bureau were to supporting the Challenge TB project. She confirmed that the meeting had fruitful discussions from various organizations that could be used towards the successful control of TB infections. She encouraged the team to document their work so that all the stakeholders are able to learn and share from the experiences.