2. ACHIEVING THE TARGETS: WHAT NEEDS TO BE DONE

2.1 Partnership vision, mission and targets

The Stop TB Partnership has a clear and consistent vision, mission and set of targets.

Vision

The Stop TB Partnership's vision is a TB-free world.

Mission

The Partnership's mission is:

- to ensure that every TB patient has access to effective diagnosis, treatment and cure;
- to stop transmission of TB;
- to reduce the inequitable social and economic toll of TB;
- to develop and implement new preventive, diagnostic and therapeutic tools and strategies to stop TB.

Targets

The Partnership has the following specific targets:

- ***By 2005, and to be sustained or exceeded by 2015:*** At least 70% of people with infectious TB will be diagnosed (i.e. under the DOTS strategy) and at least 85% of those diagnosed will be cured.
- ***By 2015:*** the global burden of TB disease (disease prevalence and deaths) will be reduced by 50% relative to 1990 levels.

  Specifically, this means reducing prevalence to 155 or fewer per 100 000 population, and reducing deaths to 14 or fewer per 100 000 per year by 2015, including people coinfected with TB and HIV. The number of people dying from TB in 2015 should be less than 1 million.
- ***By 2050:*** TB will be eliminated as a global public health problem. Using the criterion for TB elimination adopted in the USA, this means that the global incidence of TB disease will be less than 1 per million population.

In addition, the Partnership is committed to meeting the Millennium Development Goal relevant to tuberculosis (goal 6, target 8) "to have halted and begun to reverse the incidence [of TB] by 2015". The interpretation of target 8 is that the incidence rate of all forms of TB should be falling by 2015.

These targets cover short-term process targets related to the implementation of DOTS as well as epidemiological impact targets for 2015, linked to the indicators for target 8 of Millennium Development Goal 6[9]. Achievement of these impact targets globally requires sustained progress in implementation. National control programmes around the world must reach at least 70% case detection and 85% treatment success, but they must also implement the wider range of activities described in this Global Plan. The results will be a major milestone on the way to achieving the Partnership's long-term target of eliminating TB as a public health problem by 2050.

2.2 Partnership strategic directions and objectives

Partnership strategic directions

To accelerate progress, the Partnership's **twin strategies** for the next 10 years will be to accelerate the development and use of better tools, and to implement a new WHO-recommended Stop TB Strategy, based on DOTS and including the International Standards for TB Care.

Results of the analytical modelling work that underpins this plan confirm that this twin track will be crucial for meeting the targets in full. They suggest, for example, that optimal use of existing tools as set out in this plan will achieve the 2015 targets in the highest burden countries, including China and India, but that new tools will be needed to meet the same targets in Africa and Eastern Europe. The introduction of effective new tools will be a prerequisite for meeting the longer-term target to eliminate TB. WHO calculates that, at the average rate of decline in TB incidence expected globally between 2010 and 2015 under this Global Plan, the incidence rate will still be about 100 times larger than the elimination target of 1 per million. We will not secure elimination without new technology, probably for mass treatment of latent infection or mass vaccination.

Tackling TB is not a sprint but a marathon, given the long cycle of the disease. Since one third of the world's population is already infected with latent TB, even if transmission could be stopped tomorrow, we would still expect some 100 million people to develop TB during their lifetime. A person infected in childhood has an appreciable chance of developing the disease in old age, when waning immunity allows TB to flare up. But our current challenge is much greater since transmission of TB is still continuing. Success will require long-term commitment and long-term, sustainable financing.

Partnership objectives

In order to achieve our mission and make our vision a reality, **the objectives** of this strategic plan are to:

- Promote wider and wiser use of existing strategies to interrupt TB transmission by:
  - increasing access to accurate diagnosis and effective treatments by accelerating DOTS implementation to achieve the global targets for TB control; and
  - increasing the availability, affordability and quality of anti-TB drugs.
- Derive strategies to address the challenges posed by emerging threats by adapting DOTS to prevent and manage multidrug-resistant TB, and to reduce the impact of HIV-related TB.
- Accelerate the elimination of TB by:
  - promoting research and development for new TB diagnostic tests, drugs and vaccines; and
  - promoting adoption of new and improved tools by ensuring appropriate use, access and affordability.

BOX 1: WHO-RECOMMENDED STOP TB STRATEGY

SIX KEY ELEMENTS

1. **Pursue quality DOTS expansion and enhancement**, improving case-finding and cure through an effective patient-centred approach to reach all patients, especially the poor.

2. **Address TB/HIV, MDR-TB and other challenges**, by scaling up TB/HIV joint activities, DOTS-Plus, and other relevant approaches.

3. **Contribute to health system strengthening** by collaborating with other health programmes and general services, for example in mobilizing the necessary human and financial resources for implementation and impact evaluation, and in sharing and applying achievements of TB control.

4. **Involve all care providers**, public, nongovernmental and private, by scaling up approaches based on a public-private mix (PPM), to ensure adherence to the International Standards of TB Care.

5. **Engage people with TB and affected communities** to demand, and contribute to, effective care. This will involve scaling up community TB care; creating demand through context-specific advocacy, communication and social mobilization; and supporting development of a patient's charter for the tuberculosis community.

6. **Enable and promote research** for the development of new drugs, diagnostics and vaccines. Research will also be needed to improve programme performance.

The Stop TB Partnership's Global Plan for 2006-2015 adopts the new WHO-recommended Stop TB Strategy (Box 1). The Stop TB Strategy provides a comprehensive and inclusive vision for global TB control, incorporating human rights imperatives and health system strengthening.

The rest of this section highlights the key approaches to be taken in pursuing the Partnership's objectives. Summaries of individual working group plans and the Partnership Secretariat plan are given in Part III.

2.3 Promoting wider and wiser use of existing strategies for TB control

Increasing access to accurate diagnosis and effective treatment through DOTS

The DOTS Expansion Working Group (DEWG) provides the focus for implementation activities, assisting countries to improve access to quality DOTS and laying the foundation for implementation activities by the DOTS-Plus and TB/HIV Working Groups. The work of these three implementation working groups is increasingly converging. Within the life of this Plan, the Partnership will review the most appropriate structure of working groups for contemporary needs. The DOTS Expansion Working Group will also pave the way for early introduction of the new tools expected to become available as a result of the efforts of the working groups on new TB diagnostics, drugs and vaccines. The country-level activities of the Advocacy, Communication and Social Mobilization Working Group will build on the plan for DOTS Expansion.

The DOTS Expansion Working Group will continue to prioritize the 22 TB high-burden countries that together account for 80% of the global TB burden. These countries will receive an increased level of technical assistance through the DEWG, and a detailed report on them will be included in the annual WHO report on global TB control report. In addition, the designation of HBC will be used to advocate for intensified efforts and increased resources for TB control.

In 2006–2015, the DOTS Expansion Working Group will assist countries to implement the following interlinked activities:

- Achieve complete **coverage of basic DOTS** services, so that all public health units in all countries provide TB care according to the DOTS strategy by 2010. Some countries do not yet provide free treatment under DOTS for people with sputum smear-negative pulmonary TB or extrapulmonary TB, or for children with TB. In addition, all countries should work towards free provision of sputum smear microscopy and other TB diagnostic tests, and make isoniazid preventive treatment available for children.
- **Improve the quality of DOTS** by increasing the competence

and availability of human resources for undertaking DOTS tasks, and strengthening laboratory capacity for sputum smear microscopy and culture, drug management, supervision, and recording and reporting. The target is to ensure that all countries provide quality diagnosis and treatment.

- **Prioritize the needs of the poor and vulnerable.** Access to quality TB services should not be determined by type of TB, financial capacity, or social status. Given the low socioeconomic status of most people with TB, a pro-poor and equity-based approach requires that health services pay special attention to the needs of the most disadvantaged groups. This means identifying barriers and implementing measures aimed at ensuring early diagnosis and effective treatment in order to reduce the social and financial burden of the disease for patients. Specific options for addressing poverty in DOTS implementation are considered in section 3.3.
- Introduce or scale up **the public-private mix approach in DOTS**, to involve all relevant health care providers – public and private – in providing effective TB services and applying the International Standards of TB Care. Depending on the setting, this approach may include medical colleges, general hospitals, health services under insurance schemes, prison health systems,[10] army health services, NGO health facilities, corporate health facilities, private specialists and general practitioners, private pharmacies, and the informal private health care sector. While there is a potential role for all providers in delivering proper TB care, national TB programmes will need to strengthen their stewardship functions, including regulation, financing, monitoring, evaluation and surveillance. Guidelines for implementing a public-private mix (PPM) approach in DOTS have recently been developed by the PPM Subgroup[11].
- Introduce or scale up community DOTS initiatives, to allow communities to contribute to TB control, e.g. by promoting adherence to treatment and facilitating case-finding. By 2010, all countries in Africa will have scaled up **community DOTS** initiatives and by 2015, about 1.9 billion people will live in areas with community DOTS initiatives. In countries with high HIV prevalence, there will be an overlap between TB and HIV community involvement, i.e. in case-finding and case-holding for TB treatment and antiretroviral therapy. A community contribution to TB control improves access to care, fosters a patient-centred approach to the management of TB, and has resulted in improved treatment success rates through decreased default and transfer out rates. While the type and scope of community involvement depend on location and context, many high-burden countries regard civil society as an essential partner in providing support to patients and their families. The Partnership will support the forthcoming Patients' Charter for the Tuberculosis Community (under development in tandem with the International Standards for Tuberculosis Care).
- Introduce or scale up the **Practical Approach to Lung Health (PAL)**, a comprehensive, symptom-based approach to managing patients with respiratory symptoms within the primary health care system, aimed at improving the diagnosis of TB and the management of other chronic respiratory conditions. PAL includes standardization of clinical care procedures through the development and implementation of clinical practice guidelines, and coordination between health care levels within the district health system as well as among the various players in the health system. By 2005, PAL activities were in progress in 17 countries, and five others had requested WHO's collaboration in developing PAL.
- Introduce or scale up facilities and technical capacity for **mycobacterial culture services and drug susceptibility testing, and the incorporation of new diagnostic tools**. While high quality sputum smear microscopy is the cornerstone of DOTS, and remains the key to case detection and TB control, the strengthening of services for culture of M. tuberculosis and for drug susceptibility testing (DST) is necessary, especially where the prevalence of HIV or MDR-TB is high. New diagnostic tools, expected to be introduced from 2008, will gradually replace sputum smear microscopy, conventional culture and DST. Countries will then require assistance with registration of new products, formulation of new policies, purchase of equipment, training and supervision of staff, and costs.

Increasing the availability, affordability and quality of anti-TB drugs

An uninterrupted supply of high quality, affordable, first-line drugs for TB control is critical to the achievement of Partnership targets. The Global Drug Facility (GDF), which is operated by the Partnership Secretariat and which will merge with the Green Light Committee for second-line drugs, will work to **increase the availability of affordable, high quality drugs** in all countries where there is need. The GDF stimulates the development of viable markets for TB control products, other than first-line drugs. By 2010 GDF systems will be prepared for the introduction of new drugs and new diagnostic tests, as well as the harmonized supply of TB/HIV treatments.

Advocacy, communication and social mobilization

There is an urgent need for a**dvocacy, communications and social mobilization (ACSM)** in endemic countries, directed at rapidly building a multilevel, multisectoral social movement to eliminate TB. Achieving a high level of social commitment within heath service delivery systems is particularly crucial in the context of TB. There is a need for processes that will help and empower communities to take ownership of and drive the agenda for TB elimination. Rigorous application of communication and social mobilization strategies will contribute to achieving the Partnership's targets.

The vision of the ACSM Working Group at country level is the establishment and funding of evidence-based and country-driven ACSM activities aimed at bringing about sustainable societal and behavioural change. The formulation of strong country ACSM plans needs to be supported by adequate in-country human and financial resource commitments. Additionally, the ACSM Working Group will mobilize assistance to countries in

the form of tools and franchising, training, technical advisers, opportunities for information exchange, and regular formal assessments to ensure effective ACSM programming. Specific plans will be developed to provide training opportunities and tailored needs-based inputs to individuals and public sector institutions, with the aim of rapidly strengthening in-country ACSM capacities.

Effective global advocacy is essential to place TB high on the political and development agenda in donor countries and in countries with high or medium TB incidence, foster political will, and increase financial and other resources on a sustainable basis. The ACSM Working Group will seek to achieve this by: broadening the coalition of Stop TB advocacy partners; linking TB advocacy with other global social movements, especially HIV/AIDS; fostering prominent TB champions; empowering patients and communities; and mobilizing strategically timed and focused initiatives aimed at policy-makers, legislators, funding institutions and the media.

2.4 Strategies to address the challenges posed by emerging threats

Additional strategies that build on the core foundation of the DOTS strategy are needed to address the challenges posed by MDR-TB and HIV.

Adapting DOTS to prevent and manage multidrug-resistant TB: DOTS-Plus

There are both preventive and restorative strategies to combat resistance to TB drugs – DOTS and DOTS-Plus – since DOTS alone is not sufficient to curb the TB epidemic in countries with high rates of multidrug-resistant TB and large proportions of re-treatment cases. The control of MDR-TB requires sound implementation of DOTS to prevent the development of new cases plus careful introduction of second-line drugs with adequate laboratory support to stop the amplification and circulation of resistant strains.

The priorities for the next decade are to:

- expand drug resistance surveillance (DRS);
- monitor trends and regularly update the global estimates of MDR-TB;
- strengthen capacity for quality-assured culture and drug susceptibility testing;
- dramatically scale up MDR-TB treatment according to WHO guidelines, since currently less than 2% of the total number of estimated culture-positive MDR-TB patients are treated appropriately;
- create a healthy and competitive market of quality-assured second-line drugs;
- provide technical and global coordination to accomplish the goals.

Strengthening of health systems and the health workforce to deliver sound diagnosis and treatment to all MDR-TB patients will be essential.

The vision of the Stop TB Working Group on DOTS-Plus for MDR-TB is the integration of drug resistance surveillance and the management of MDR-TB as routine components of TB control, providing access to diagnosis and treatment for all TB patients and by all health care providers, regardless of drug susceptibility patterns. This is in line with the new WHO-recommended Stop TB strategy, which encompasses all TB patients, including those with MDR-TB and HIV. As a result, all MDR-TB management measures will be implemented in collaboration with DOTS expansion and strengthening activities, and in line with the activities of the other Partnership Working Groups.

The countries with a high prevalence of MDR-TB are those of the former Soviet Union, China and India, which together account for almost three-quarters of the estimated global TB burden.

Reducing the impact of HIV-related TB

The key strategy is to reduce the global and individual burden of HIV-related TB by scaling up implementation of collaborative TB/HIV activities in countries with a high burden of TB/HIV. The severity of the TB/HIV epidemic in Africa merits particular and urgent attention. The strategic plan of the TB/HIV Working Group for 2006–2015 also reflects the Blueprint for Africa 2006–2007, a more detailed plan for intensified, short-term action, developed to accelerate progress in the region. This Blueprint for Africa was adopted by the Regional Committee for Africa, in its declaration of TB as an emergency in August 2005.

The international standards for TB/HIV collaboration have been set in WHO's Interim policy on collaborative TB/HIV activities,[12] which builds on DOTS TB programmes and HIV/AIDS programmes to provide comprehensive TB and HIV prevention, care and support services to reduce the impact of HIV-related TB. The policy sets out specific activities at country level to address the dual epidemics, including:

- establishing mechanisms for collaboration, including a coordinating body for TB/HIV activities, surveillance of HIV prevalence among TB patients, joint TB/HIV planning, and monitoring and evaluation;
- decreasing the burden of TB among people living with HIV/AIDS (PLWHA) – through intensified case-finding for earlier detection of active TB, provision of isoniazid preventive therapy (IPT) for coinfected patients, and TB infection control in health care and congregate settings.
- decreasing the burden of HIV among TB patients – through provision of voluntary counselling and testing for people at risk of HIV, introduction of HIV prevention and co-trimoxazole preventive therapy, HIV/AIDS care and support, and introduction of antiretroviral therapy (ART).
- improving the care of people who are infected with both TB and HIV, through training and collaborative care initiatives.

Some gaps in the interim policy remain to be filled (e.g. regarding TB/HIV services for intravenous drug users), and the policy must be refined and adapted to address the needs of populations at risk on the basis of country experience and new research. Nonetheless, the priority is now to deliver, monitor and maintain its standards. Implementation of the interim policy in all high-

burden settings is therefore at the core of the TB/HIV strategic plan for 2006–2015.

The activities to be undertaken by the TB/HIV Working Group and its partners over the next 10 years to achieve the 2015 targets can be grouped in the following four broad areas:

- **to scale up implementation and expand the scope of collaborative TB/HIV activities;**
- **to develop and coordinate the research** necessary to improve the prevention, early diagnosis and rapid treatment of TB in PLWHA, and incorporate the results into global policy;
- **to increase political and resource commitment** to collaborative TB/HIV activities;
- **to contribute to strengthening health systems** to carry out TB/HIV activities.

Target countries are all those with a generalized HIV epidemic (adult HIV prevalence >1%) and large countries in which there are administrative areas with an adult HIV prevalence >1%.

2.5 Operational research

For any public health activity, operational research is necessary to determine the best ways of implementing interventions and to monitor their impact. Operational research is thus crucial in determining how to increase access to accurate diagnosis and effective treatment through the DOTS strategy, and how to adapt the DOTS strategy to address the challenges posed by drug resistance and HIV. Operational research involves the evaluation of programme operations, aimed at improved policy-making, better design and operation of health systems, and more efficient methods of service delivery. Financial and technical support is required to enhance local capacity for operational research (see Table 4). National plans for TB control should include budgeted activities for operational research as a routine part of programme activities.

2.6 Promoting development and adoption of new TB diagnostic tests, drugs and vaccines

New tools will be of critical importance in achieving the Partnership's targets, particularly in Africa and Eastern Europe, and essential to securing the Partnership's vision of eliminating TB – hence the need to invest now to reap future benefits.

New diagnostic tests

More than a century after its development, the microscopic examination of sputum is still the only widely available diagnostic tool in most developing countries for identifying TB. Unfortunately, it has a sensitivity of only 40–60% under field conditions, falling as low as 20% in the presence of HIV coinfection. Yet even this limited diagnostic test remains beyond the reach of the majority of TB patients. In resource-limited settings, drug susceptibility testing, if available, is usually performed only after treatment has failed, which represents a missed opportunity to interrupt transmission.

One third of the population of the world has a latent infection with M. tuberculosis. Preventive therapy effectively reduces progression to active disease, but there is currently no way to predict which subjects are at greatest risk of progression.

The vision of the Working Group on New TB Diagnostics is the development and introduction of cost-effective and appropriate new diagnostic tools, which perform equally well in HIV-infected subjects, to:

- improve TB case detection, through increased sensitivity and specificity and improved accessibility; simple, accurate, inexpensive tests that can be performed at low levels of the health care system and that produce results on the same day are the ultimate goal;
- rapidly and inexpensively identify drug-resistant TB, permitting timely, effective treatment to reduce both individual morbidity and continuing transmission;
- reliably identify latent TB infection and determine the risk of future progression to active disease, allowing rational use of preventive therapy.

The three objectives for 2006–2015 of the Working Group on New TB Diagnostics are to:

- **address existing gaps in knowledge** that are obstructing development of new diagnostic tools;
- **develop and evaluate a portfolio of new diagnostic tools** and demonstrate their impact;
- **implement new diagnostic tools** and ensure access to them.

The greatest impact on public health in the area of TB diagnostic tests is expected to come from a highly accurate testing device that can be used in the field. The Working Group plans to promote and finance research in this area, building on advances in mycobacterial genome sequencing and expression profiling. It is anticipated that this information will facilitate the development of improved test strips suitable for use at the first point of care, and that during 2006–07 an improved test (for use on blood, serum, urine or saliva) will be developed.

New drugs

The vision of the Working Group on New TB Drugs is to have new TB regimens that will achieve cure in 1–2 months or less, rather than 6–8 months as now, will be effective against MDR-TB, will be compatible with antiretroviral therapy, and will be effective against latent TB infection. In addition, new regimens need to be affordable and easily managed in the field. This is an extremely challenging goal, but it must be met if we are to change the face of TB therapy. If progress in the basic understanding of the biology of M. tuberculosis continues, it is conceivable that the course of therapy could be reduced even further, to 10–12 days, before 2050, or that additional advances in therapeutic or prophylactic options may also greatly reduce TB incidence.

To achieve this vision, the Working Group has developed its strategic plan for 2006–2015 around the following areas of strategic importance:

- **basic discovery biology**, to identify and validate new targets for drugs, and to identify candidate compounds using effective screening and creative medicinal chemistry;
- **drug development**;
- **planning and execution of more effective clinical trials**, including identification of improved biomarkers and methods of assessing latent disease;
- clear and efficient **regulatory guidance**.

Eleven compounds with novel modes of action against TB are currently in clinical or advanced preclinical development. Some of these compounds, for example moxifloxacin, have been shown to reduce treatment time in animal models. The target by 2010 is the introduction of a new drug or combination of drugs that can reduce treatment duration to 3–4 months. New in vitro data suggest that compounds under development could reduce treatment duration even further. Genomic and microbiological research on novel targets supports optimism that a one-month treatment for TB is attainable and could be in clinical trials by 2015. Combining agents that attack different targets could maximize the therapeutic effectiveness of new regimens.

Only about 10% of candidate products entering the clinical pipeline advance to registration, mostly because of concerns about safety. Thus, a robust and sustained pipeline of new candidates and back-up discovery programmes is essential to success.

Affordability, adoption of, and access to new drugs, and the implementation of new regimens, are intimately linked to the manufacture and production of medicines, alone or in combination, and to the adoption of such therapies as international standards. The Working Group will therefore continue to work closely with the other working groups of the Stop TB Partnership, ministries of health, international health agencies and in-country field workers to understand their needs, in order to ensure rapid and successful introduction and adoption of the new regimens in the field. Experience has shown that the establishment of standard treatments and their subsequent implementation in the field can take years, particularly in TB control. All Stop TB Partnership working groups and the international community will need to focus on the safe, prompt and effective adoption of new tools.

New vaccines

The introduction of new, effective TB vaccines will be an essential component of any strategy to eliminate TB by 2050. Efforts to develop such vaccines are gaining substantial momentum. Scientific results from the laboratory and from early field trials have been encouraging and consistent. New TB vaccines to prevent childhood and adult forms of TB, to reduce TB in people coinfected with HIV, and to shorten drug treatment regimens will fundamentally alter our approach to TB control.

It is probable that the next generation of vaccines will work by complementing the immune response induced by the current BCG vaccine. New vaccines could be delivered together with BCG to young children before they are exposed to M. tuberculosis, as a separate booster to young adults, or as an adjunct to chemotherapy. The Working Group on New TB Vaccines is promoting research on several approaches to the development of new candidate vaccines and new delivery strategies.

The overall objective of the Working Group for 2006–2015 is to have **a safe, effective, licensed vaccine available at reasonable cost by 2015**. Its objectives and workplan for 2006–2015 are to:

- **maintain and improve BCG vaccination programmes**, since it is anticipated that BCG will remain the cornerstone of TB vaccination programmes over the period covered by this Global Plan, with the next generation of new vaccines introduced as an addition to BCG vaccines, which are commonly given at birth in many countries. This requires BCG production to be sustained by a diminishing number of international suppliers.
- **expand discovery and translation research on vaccines** ("keeping the pipeline filled");
- **facilitate preclinical development** of new vaccines;
- **build capacity at vaccine trial sites**, providing opportunities for training and capacity strengthening;
- **ensure availability of vaccine production capacity/scale-up**, requiring the development of innovative partnerships with manufacturers in developing and developed countries;
- **perform clinical trials**, and ensure that collaborators in developed and developing nations make the necessary commitment of investments.
- **provide an enabling infrastructure**.

2.7 Technical cooperation

The Stop TB Partnership provides the platform for coordinated technical support to countries, consensus on unified approaches and frameworks for monitoring and evaluation, and assistance to national TB control programmes. Consistent and focused technical cooperation to support implementation of DOTS has been a mainstay of accelerated TB control scale-up in high-burden countries over the past decade. National TB Programmes, as well as major nongovernmental providers, have benefited from guidance and assistance from a wide range of technical cooperation partners[13] in capacity development, planning, resource mobilization, focused problem-solving, monitoring and evaluation.

The Global Fund to Fight AIDS, Tuberculosis and Malaria is now providing unprecedented levels of external financing for national TB control efforts. With this new financing mechanism, a host of new implementation challenges confront recipients and their partners. If obstacles to country implementation efforts are to be overcome, the important Global Fund financing has

BOX 2: EXAMPLES OF MECHANISMS FOR RAPID TB TECHNICAL ASSISTANCE FOR COUNTRIES

- ***DOTS Expansion Working Group*** – coordination of major technical partners
  - Regular shared calendar of joint and single agency missions in countries.
  - Annual meetings to coordinate activities, share best practices and address common technical challenges.
  - Annual joint missions in countries.
- ***ISAC*** (Intensified Support and Action Countries) – Joint initiative of Stop TB, WHO, bilateral donors, the Global Fund, and technical partners, to support managerial and technical capacity-building to increase countries' capacity to make effective use of new funds; first phase – China, India, Indonesia, Kenya, Pakistan, Romania, Russian Federation and Uganda.
- ***TB CAP*** (Tuberculosis Control Assistance Program) – USAID-funded consortium of eight technical assistance partners to support capacity-building, country-level programme implementation and scale-up, and advocacy in USAID-funded countries.
- ***Back-up Initiative*** (financed by GTZ) – support for selected countries in planning and preparing proposals to the Global Fund.
- ***High-level missions*** of Stop TB Partnership Board members to priority countries to help meet policy and financial challenges

to be matched by technical support. A range of mechanisms are available for coordinating the provision of rapid technical assistance.
See Box 2: Examples of mechanisms for rapid TB technical assistance for countries

Countries have benefited from the support of technical partners in preparing Global Fund grant proposals. In Round 4 (2004) of Global Fund applications, the TB grant success rate of countries that had received technical assistance was 64% compared with 40% of countries without assistance.

The crucial need now is for support for implementation. The credibility of the Global Fund, its investors, and the technical cooperation agencies rests on effective implementation at country level. However, the financing gaps for the technical partners have not yet been addressed in a consistent and adequate fashion. This amounts to an "underfunded mandate" that has ripple effects on all of the organizations' functions. The capacity of Stop TB partners to respond can no longer meet the demand from the 130 countries receiving Global Fund grants. WHO, other UN agencies and nongovernmental organizations (NGOs) – all of which are heavily dependent on voluntary contributions – are chronically under-resourced compared with the scale of assistance needed to help countries make effective use of their large grants.

The total cost to partners of providing technical assistance over the 10 years from 2006 to 2015 is estimated to be US$2.9 billion. This sum is included in the estimates of the total cost of implementing the Global Plan.

2.8 Monitoring and evaluation

The Global Plan to Stop TB must remain relevant for all partners throughout its lifetime (2006–2015). Any ten-year plan will need to be adjusted in the light of changing circumstances. Each Working Group plan therefore sets out specific measures for monitoring and evaluation, and fruitful areas for much-needed operational research.

One of the ground-breaking elements of the DOTS strategy has been its clear methods for routine case notification, reporting, treatment cohort analysis, supervision for validation, and related performance indicators. DOTS-based recording and reporting systems are in place in over 184 countries. WHO is developing a coalition on impact measurement, with technical partners in high-burden countries, international and national agencies, and academia, in order to devise improved standard evidence-based methods of measuring the epidemiological impact of TB control measures. This will include TB prevalence surveys, household health surveys, modelling and analysis of routine data. These approaches are urgently needed to measure progress towards the MDG and Partnership impact targets.

Overall, the Partnership Secretariat has a fundamental role in monitoring and evaluation of the Partnership and the Global Plan. As a result of such monitoring and evaluation, the Secretariat will propose tactical revisions to the Global Plan that would enable faster progress towards targets.

The Partnership Secretariat will report to the Partners' Forum (at least every three years) and Coordinating Board (annually) on progress towards the achievement of the Global Plan targets. In collaboration with the working groups, the Secretariat will monitor working group inputs and measure progress towards the targets. In addition the Secretariat will facilitate a mid-term review and progress report in 2011. In 2015 it will provide a final report on the Global Plan and coordinate development of a further Global Plan for the next period.