

Independent External Evaluation of the Global Stop TB Partnership

ANNEXES

DECEMBER 2003



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ANNEX A: INDEPENDENT EVALUATION OF THE GLOBAL STOP TB PARTNERSHIP - TERMS OF REFERENCE

May 29, 2003.

Purpose

The evaluation is being commissioned by the Stop TB Partnership Secretariat at the World Health Organization at the request of the Coordinating Board of the Global Partnership to Stop TB. The purpose of the evaluation is to examine the functions and structure of the Partnership and its components, and the degree to which the functions of the Partnership foster progress at the country level. The fundamental question to be addressed is "Does the Partnership add value to the global efforts to control tuberculosis over and above what would be accomplished without the Partnership?" The expected result is recommendations to help expand the strengths and overcome the weaknesses of its structure and interactions in order to improve the capacity of the Partnership to achieve its mission over the next five to seven years.

Context

The Global Partnership to Stop TB is a global movement to accelerate social and political action to stop the unnecessary spread of tuberculosis around the world. "Our vision is a TB-free world. The first children born this millennium will see TB eliminated in their lifetime." The Stop TB mission is to increase access, security, and support to:

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

The approach is a coordinated, multinational, multisectoral global effort to control TB. The Partnership operations are outlined within "The Global Plan to Stop TB", a consensus document that is a road map to the work programme of the Partnership from 2001 up to the year 2005.

The Stop TB Partnership is not a separate legal entity, but a group of entities working with a common goal, and with a Secretariat embedded within the World Health Organization (WHO). The Secretariat includes functions to support the Partnership and the Coordinating Board, to carry out communications and advocacy and to manage the Global Drug Facility.

The Partnership will:

1. Promote wider and wiser use of existing strategies to interrupt TB transmission, by:
 - increasing access to accurate diagnosis and effective treatments by accelerating expansion of DOTS to achieve the global target for TB control.
 - increasing the availability, affordability, and quality of TB drugs.
2. Adapt existing strategies to address the challenges posed by emerging threats, by:
 - developing an effective strategy to prevent and manage multi-drug resistant TB.
 - developing an effective strategy to reduce the impact of HIV-related TB.
3. Accelerate elimination of TB, by:

- promoting research to develop new and improved diagnostic tests, drugs and vaccines.
 - promoting adoption of new and improved tools by ensuring access and affordability.
4. Promote use of the Global Drug Facility (GDF), which is a project of the Stop TB Partnership. By securing the timely supply of quality TB drugs, the GDF will complement other activities designed to improve coverage and quality of global TB control.

The strategic objectives of the Partnership are:

- ◆ to expand DOTS coverage
- ◆ to adapt DOTS to address the challenges of HIV-TB co-infection and multi-drug resistant TB
- ◆ to accelerate the development of new and improved TB drugs, vaccines and diagnostics
- ◆ to broaden the Partnership.

The Coordinating Board, six Working Groups, the Task Force(s) and the Secretariat put the strategy into action.

The Partnership was first launched as the Stop TB initiative in 1998. As set out in the Basic Framework for the Global Partnership to Stop TB adopted in 2001, its structure includes the Partners' forum, the Coordinating Board, the Secretariat, and six Working Groups.

The Coordinating Board comprises six constituencies: technical agencies and non-governmental organisations, multi-lateral organisations, geographic regions, countries with a high TB disease burden, donors, and technical Working Groups. In addition, a representative of the WHO Scientific and Technical Advisory Committee on TB (STAG) sits on the Coordinating Board to ensure policy coherence. A working committee of the Coordinating Board has been formed to advise the Secretariat on urgent matters between Coordinating Board meetings.

A number of other Partnership components have been formed. The Green Light Committee has been established by a group of Partners to ensure safe use and access to second line anti-TB drugs against multi-drug resistant TB where appropriate. A Global Drug Facility has been established and is managed by the Secretariat. An independent technical review committee provides advice to the Coordinating Board on proposals to the Global Drug Facility. A task force on communication provides coordination and formulates communication and advocacy plans for the Partnership. A trust fund holding pooled Partnership financial resources has been established under the control of the Coordinating Board. At present, trust fund resources fund Partnership activities such as the Global Drug Facility and the Partners' forum.

The Stop TB Partnership has completed some three years of operation in its present configuration. In the coming years, the Stop TB Coordinating Board wishes to consider how the Partnership can best evolve to meet its strategic objectives and achieve its mission. In order to fulfil these objectives it is anticipated that initiating and continuing key areas of work will be crucial. These are listed below under the objective headings:

1. Expanding DOTS coverage:

- ◆ accelerating DOTS expansion, and improving the implementation of DOTS, such as by increasing case detection, and to improve access and use especially by the poor
- ◆ ensuring universal access to safe high quality anti-TB drugs and accurate diagnostic tests

- ◆ promoting sustainable financing of TB programs
 - ◆ surmounting systemic barriers to TB control and aligning Stop TB's goals with national health system development
2. Adapting DOTS to address the challenges of HIV-TB co-infection and multi-drug resistant TB:
- ◆ ensuring that second line drugs are available where needed and that their use does not promote the emergent of drug resistant strains of TB
 - ◆ determining and implementing a strategy to address HIV-related TB
3. Accelerating the development of new and improved TB drugs, vaccines and diagnostics:
- ◆ facilitating the development and appropriate application of new tools for tuberculosis control
4. Broadening the Partnership:
- ◆ fostering the development of country-level Partnerships that operate to improve tuberculosis control, thereby decreasing the incidence of the disease
 - ◆ considering whether and how to increase the level of pooled resources and developing mechanisms for their management, allocation and disbursement
 - ◆ facilitating the alignment of Stop TB's goals and activities with those of the new Global Fund to Fight AIDS, TB and Malaria (GFATM) and other key Partners
 - ◆ building on existing communication and information systems to accelerate Partner collaboration globally, regionally and nationally
 - ◆ ensuring that the advocacy, social mobilization, and innovation roles of the Partnership are optimally paired with the policy development, technical capacity and in-country presence of WHO

As Stop TB moves from the start-up phase towards sustainable operations, the Coordinating Board has decided that an independent external evaluation of the Stop TB Partnership should be commissioned. These are the terms of reference for the evaluation.

Guiding principles of the evaluation

- ◆ Target the Coordinating Board as the initial audience¹, followed by all Partners in the movement to Stop TB.
- ◆ Be issue oriented, forward looking and cost effective.
- ◆ Avoid duplication of efforts and capitalise on ongoing processes and findings (e.g.: Global Drug Facility evaluation).
- ◆ Use stakeholder views as primary source of information and, in this respect; take advantage of relevant venues (Working Group meetings, etc) for stakeholder feedback.
- ◆ Satisfy the requirements for independent review of the World Bank Development Grant Facility.

Scope of the evaluation

The evaluation extends to all elements of the Partnership at primarily at global level, but should also evaluate the impact of the Partnership at regional and national levels, and must

¹ Note that as a component of the Partnership, the Coordinating Board is also a subject of the evaluation. Therefore, the evaluation must be truly independent.

include the beneficiaries' viewpoint. The aspects of the Partnership to be evaluated are its relevance, efficacy, efficiency, sustainability, institutional development impact, process, governance and implementation. These terms are further defined below.

Outcomes of the evaluation

This is not a performance evaluation so much as an enquiry as to the optimal structure and function of the Partnership as it seeks to carry out its mission. The outcomes should be an evaluation of the Partnership and its components (e.g.: Coordinating Board, Secretariat, etc.) and recommendations in the form of a roadmap that the Partnership can use in:

- ◆ increasing the value it provides to TB control at global, regional and national levels, and
- ◆ making the transition between start-up phase and sustainable operations.

Further the evaluation should recommend indicators of Partnership performance (beyond technical indicators of TB control), which can be used to monitor the progress of the Partnership in achieving its objectives.

The evaluation report should comprise the following sections:

- ◆ specific description of the Partnership's objectives, structure, activities and of the units being evaluated
- ◆ methodology used to develop the evaluation findings
- ◆ responses to each of the seven core evaluation questions listed below
- ◆ description of administrative covenants and assessment of the extent to which these have been satisfied
- ◆ summary of key findings
- ◆ conclusions and lessons learned
- ◆ recommendations including specific recommendations on governance and options for reform

The evaluation team shall make a presentation of key finding to the Coordinating Board at its next meeting in The Hague, October 2003

Core evaluation questions²

1. Relevance: To what extent is the work of the Partnership consistent with the overall development strategy and with the policy priorities of its principal stakeholders? What is the Partnership's comparative advantage (relative to other organisations)? What value does having a Partnership add to global tuberculosis control efforts? What is the relevance at the country level? What is the political commitment to the Partnership among key stakeholders?

2. Efficacy: To what extent does the Partnership achieve its stated mission and targets?

3. Efficiency: To what extent are the benefits flowing from the Partnership commensurate with inputs in terms of cost and time of implementation? Is resource management optimal or how could it be improved?

4. Sustainability: What is the likelihood that the Partnership's benefits and results will be maintained over the intended time period? In other words, what is the resilience to risks (technical, economic, institutional, environmental, etc) of the net benefit flows over time?

² See annex II for more details.

5. Institutional development impact: To what extent does the Partnership contribute to improved practices through its component elements (Coordinating Board, Secretariat), Partners and direct beneficiaries of support in terms of their impact on TB control? Do the members of the Coordinating Board represent the key stakeholder constituencies and if not, how can the Partnership foster the participation of these constituencies within the TB community? What is the relationship of the Stop TB Partnership to other global TB initiatives - primarily the Global Fund to Fight AIDS, TB and Malaria?

6. Process, governance and implementation: Regarding organisational relationships and authorities, to what extent has the Partnership worked well as planned? What communication pathways are needed within the Partnership structure? How best can the Partnership structure accommodate new ideas and new areas of focus? What barriers have been encountered and how have they been surmounted? To what extent is the Partnership design appropriate for its mission, particularly the position, function and governance of the Coordinating Board?

Are resources managed optimally? How are pooled Partnership funds managed and allocated? What is the financial tracking and reporting system and how can it be optimised? Has the work of the Partnership been realistically planned, understood by all parties and managed effectively in terms of its administrative, legal, human resource and financial aspects? Is ongoing monitoring and evaluation conducted and do findings and recommendations result in subsequent modifications?

7. Coordination: What are the structure, role, function and authority of the Coordinating Board and its Working Committee and what should they be? Are all important constituencies represented on the Coordinating Board? How do the Coordinating Board and Working Committee work? Does the structure of the Coordinating Board facilitate the job of the Working Groups? How are emerging issues communicated to the Coordinating Board? What is the Coordinating Board coordinating? How should the Coordinating Board deal with issues related to financial resources? What is the function of the Coordinating Board with respect to the Working Groups? Is the Coordinating Board successful in bringing members of the six constituencies³ into the Partnership and in enhancing coordination between them? What is the effectiveness of the Coordinating Board in doing outreach and representing the broader community?

Evaluation Methods⁴

The external evaluation should be conducted by a small team of people who are independent of the existing Stop TB Partnership. The consultants should have extensive experience in analysis of institutional arrangements, governance (including associated legal issues) and working of alliances and Partnerships, as well as in management/administration. At least one of the team should have an in depth understanding of the international health infrastructure and the Partnership context. One team member should have knowledge of infectious disease control, particularly TB control.

The evaluation team is responsible for its own logistic arrangements.

The evaluation should as far as possible include interviews with:

- ◆ all members of the Coordinating Board;

³ These constituencies are: technical agencies and non-governmental organisations, multi-lateral organisations, geographic regions, countries with a high TB disease burden, donors, and technical Working Groups

⁴ Details of issues to be examined are provided in Annex II.

- ◆ Working Group Core Groups and Secretariats;
- ◆ representatives of other Partnership components (Task Forces, etc); and
- ◆ key Partners and stakeholders, including a sample of:
 - Stop TB Partners,
 - high TB disease burden countries⁵,
 - other countries with serious TB control issues, and
 - countries receiving Global Drug Facility support.

A number of country visits are viewed as essential in order to gain an understanding of the impact of the Partnership at field level. In addition the consultants are expected to review relevant documents, observe meetings and/or teleconferences, and track decision-making processes.

In light of the key goals and objectives of the Partnership, The evaluators are expected to review:

- ◆ the current functions, interactions and impact of the Partnership and its components at global level and (through a limited sample) at regional and country levels
- ◆ the current roles and responsibilities of each component of this structure and their relationship with key Partners and beneficiaries
- ◆ the composition, staffing, structure and work schedules of the key Partnership components (e.g.: Coordinating Board, Secretariat, etc) including number of members and staff, roles, skills, how they are selected/appointed and the duration of tenure. Evaluate their capacity to meet current and future Partnership management needs. Review the contribution of human resources of Partner agencies to these groups, with a view to assessing the sustainability, in the long run, of the concept of a “lean” Secretariat
- ◆ the processes for decision-making and policy setting within the Partnership, including the respective roles, relationships between and reporting arrangements of the Partnership global and Partners. Review processes for defining and prioritising issues and agenda items for Working Group and Coordinating Board meetings and teleconferences. Review mechanisms for resolution of conflicting viewpoints
- ◆ the funding arrangements for the Partnership components at global level, to ensure there are appropriate mechanisms and budgets for funding priority activities
- ◆ planned Partnership activities including current workplans

Regional and country level investigations may be carried out through teleconferences and electronic means. Up to six short country visits should be carried out in order to evaluate:

- ◆ the impact of the Partnership on political commitment to the movement to Stop TB
- ◆ the impact of the Partnership on the availability of high quality anti-TB drugs (first and second line as appropriate)⁶
- ◆ the impact of the Partnership on TB awareness and Partnership building.

The choice of countries to be visited should be based on explicit criteria to be developed by the evaluators during the evaluation in consultation with the steering committee managing the evaluation⁷.

⁵ High burden countries are defined as the 22 countries that together constitute 80% of the TB disease burden: India, China, Indonesia, Nigeria, Bangladesh, Ethiopia, Philippines, Pakistan, South Africa, Russian Federation, DR Congo, Kenya, Viet Nam, UR Tanzania, Brazil, Thailand, Uganda, Myanmar, Mozambique, Cambodia, Zimbabwe, Afghanistan.

⁶ This work should make use of the findings of the 2003 Global Drug Facility evaluation.

⁷ Note that country visits have already taken place in the context of the evaluation of the Global Drug Facility.

Timing

The final report should not exceed 50 pages and should include an executive summary. The draft report will be presented to the Coordinating Board and circulated. The Coordinating Board may request comments from stakeholders.

The first draft of the report will be delivered to the Coordinating Board after two months of work have been completed. An advanced draft report should be sent to the Coordinating Board in late September for discussion at its October 2003 meeting. The consultants may be asked to present to the Coordinating Board.

Management of the evaluation

The Stop TB Partnership Secretariat at WHO is responsible for the bidding process, the selection of the contractor and the management of the evaluation. In carrying out this function, it is advised by a five-member Steering Committee appointed by the Stop TB Coordinating Board. This Steering Committee will guide the bidding, selection, and briefing of the evaluation team. Funding for the evaluation will be provided through Partnership pooled funds held in the Stop TB trust fund at the World Bank and through financing from the World Bank Development Grant Facility.

TOR Annex I: Key documents for the evaluation

The consultants will need to draw on the following key documents:

Basic Framework for the Global Partnership to Stop TB

Reports of the Coordinating Board meetings

Memorandum of Understanding for the Global Drug Facility

Global Plan to Stop TB

Documentation on WHO procedures, rules, regulations, rights and privileges

TOR Annex II: Details of expected outcome

The outcome of the evaluation should include recommendations in the form of a roadmap that the Partnership can use in successfully making the transition between start-up phase and sustainable operations. These recommendations should include: optimal working arrangements, responsibilities, reporting lines and composition to facilitate successful completion of the above areas of work, with a view to ensuring: appropriate staffing; clear roles and reporting arrangements; realistic workloads; maintenance of flexibility; and appropriate use of Board members' time. Where changes are proposed, the recommendations should include concise terms of reference and expectations such as recommended staffing levels where appropriate.

Highlighted issues

The following issues have been highlighted as being of particular interest to the Coordinating Board:

1. Function of the Global Partnership to Stop TB:

- ◆ How should the Partnership best reflect the needs of the movement to Stop TB in terms of function, structure and composition, scope of operation, and linkages with other movements/alliances/facilities?
- ◆ What is the comparative advantage of the Partnership in each key area of activity? In which cases should the Partnership lead and in which cases should a Partner take the lead role?
- ◆ What is the value of Stop TB as a "brand" and how can it be best maintained and exploited?
- ◆ Where is the Partnership hindering rather than helping, what are its weak points, what factors have contributed to these problems, and how can these be addressed?
- ◆ How successful is the high burden country and regional participation?
- ◆ What is the utility of the Partnership to high burden countries?
- ◆ How is the Partnership engaging new Partners? What is the effectiveness of the Partners' Forum in doing so?
- ◆ What are the main risks pertaining to the structure and function of the Partnership that threaten the achievement of its mission?
- ◆ What are the successes of the Partnership, what are the factors that have contributed to those successes, and how can these experiences be used as models by other movements/alliances?

2. Organisational relationships and authorities:

- ◆ What is and what should be the role of the Stop TB Partnership with respect to the host agency of the Secretariat, WHO?
- ◆ How can the Secretariat function most appropriately, including housing arrangements within WHO, direction by the Coordinating Board and by the Executive Secretary?
- ◆ What should the administrative and governance arrangements be for the Global Drug Facility within the Secretariat and Partnership, including the position of the Global Drug Facility manager?
- ◆ What should be the role of the Partnership Executive Secretary, what is the most appropriate level of appointment, what should his/her authority and reporting responsibilities be with respect to the Coordinating Board, and with respect to the WHO reporting structure?
- ◆ What is and what should be the authority of the Partnership Secretariat in general, with respect to the Coordinating Board and with respect to its host agency, WHO?

3. The internal workings of the Global Partnership to Stop TB:

- ◆ What role should the research/new tools Working Groups have and what is their optimal mode of participation in the Partnership and in the Coordinating Board?
- ◆ How can the inter-relations among the Working Groups be facilitated?

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- ◆ Where is the Partnership hindering rather than helping, what are its weak points, what factors have contributed to these problems, and how can these be addressed?
- ◆ How successful is the high burden country and regional participation?
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- ◆ What are the successes of the Partnership, what are the factors that have contributed to those successes, and how can these experiences be used as models by other movements/alliances?

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- ◆ How can the Secretariat function most appropriately, including housing arrangements within WHO, direction by the Coordinating Board and by the Executive Secretary?
- ◆ What should the administrative and governance arrangements be for the Global Drug Facility within the Secretariat and Partnership, including the position of the Global Drug Facility manager?
- ◆ What should be the role of the Partnership Executive Secretary, what is the most appropriate level of appointment, what should his/her authority and reporting responsibilities be with respect to the Coordinating Board, and with respect to the WHO reporting structure?
- ◆ What is and what should be the authority of the Partnership Secretariat in general, with respect to the Coordinating Board and with respect to its host agency, WHO?

3. The internal workings of the Global Partnership to Stop TB:

- ◆ What role should the research/new tools Working Groups have and what is their optimal mode of participation in the Partnership and in the Coordinating Board?
- ◆ How can the inter-relations among the Working Groups be facilitated?

ANNEX B: EVALUATION METHODOLOGY AND INTERVIEWEES

1. The evaluation

This independent external evaluation of the Global Stop TB Partnership was commissioned by the Partnership Secretariat at the World Health Organisation from the Institute for Health Sector Development, London, and Department of Community Health, University of Ghana, at the request of the Coordinating Board of the Global Partnership to Stop TB. It was overseen by an Evaluation Steering Committee of the Coordinating Board.

The purpose of the evaluation was to examine the functions and structure of the Stop TB Partnership and its components, and the degree to which the functions of the Partnership foster progress at the country level.

The scope of the evaluation extended to all elements of the Partnership primarily at global level, but also evaluated the impact of the partnership at regional and national levels, the latter primarily on the basis of six country visits. The key evaluation question posed by the Terms of Reference was *“Does the Partnership add value to the global efforts to control tuberculosis over and above what would be accomplished without the partnership?”*

The outputs of the evaluation are a set of recommendations to help the Stop TB Partnership build on the strengths and overcome any weaknesses of its structure and interactions, in order to improve the capacity of the partnership to achieve its mission, respond efficiently and become sustainable.

Stop TB Evaluation Team:

Ms Karen Caines, Team Leader
Prof Richard Biritwum
Dr Neil Cameron
Prof Adukwei Hesse
Ms Emma Jefferys
Mr Enamul Karim
Dr Hatib Njie
Mr Mark Pearson
Ms Julia Delgado, Project Officer

2. Other relevant studies/activities

The evaluation took place against the background of an independent evaluation of the Partnership's Global Drug Facility (GDF) by McKinsey & Co. from January-March 2003 and simultaneously with a number of other activities of direct relevance, notably:

- the extensive review of implementing global TB control by the 2nd Ad Hoc Committee on the TB Epidemic, convened by the DOTS Expansion Working Group
- the establishment of the Trust Fund Task Force of the Board
- Philip Hopewell's project on Re-examining the Roles and Responsibilities of the Stop TB Working Groups
- a consultancy on resource mobilisation by Finlay Craig

Given the emphasis placed by the Steering Committee and the Secretariat on the guiding principle in the evaluation Terms of Reference to avoid duplication of efforts and capitalise on ongoing processes and findings, issues covered by these studies have not been re-examined in detail by this evaluation. The team has however included the GDF in a wider examination of Secretariat performance and financial management, and reviewed progress on the GDF since the McKinsey evaluation.

3. Approach to the evaluation

In the absence of consensus on the start of the Partnership, this evaluation has focused primarily on events since the Amsterdam Declaration of March 2000 but has recognised both that some developments antedated the Amsterdam Conference and that the formal structures of the Partnership mostly came into effect in 2001.

To evaluate the Partnership at a global level, the evaluation team conducted a literature review and examined internal Partnership documents and data. In line with the Terms of Reference which specified stakeholder views as the primary source of information, 94 semi-structured interviews were undertaken with key stakeholders at global level, including Coordinating Board members, key players in the Working Groups, Task Forces, the Partnership Secretariat, WHO and a sample of partners.

The team attended as many meetings of the various components of the Partnership as possible during the period of the evaluation, including meetings of the Coordinating Board, the Working Committee, the DOTS Expansion Working Group, and the Partnership Task Force on Advocacy and Communications. It also observed a Working Committee teleconference and attended the meeting on 18-19 September 2003 of the 2nd Ad Hoc Committee on the TB Epidemic.

Preliminary findings of the evaluation were presented to the Coordinating Board on 10 October 2003. Board members and other attendees had the opportunity to discuss the findings collectively and talk individually with members of the evaluation team. [Partners were also given the opportunity to comment on a complete draft of this report before it was finalised].

To evaluate the Partnership at regional and country level, the team interviewed WHO regional advisers and selected country TB advisers, and undertook visits to six countries selected by the Evaluation Steering Committee: Afghanistan, Brazil, Cambodia, Indonesia, the Russian Federation and South Africa. The Committee's selection criteria were:

- i) only high burden countries
- ii) one country in each of the six WHO regions
- iii) if more than one high burden country in a given region, the country with the highest estimated incidence was chosen
- iv) South Africa was substituted by the Evaluation Committee for Zimbabwe, given current conditions in Zimbabwe

Tools developed for the visits included an explanatory note and questionnaire sent to interviewee/meeting participants, and a tool mapping the chronology of global partnership events against key milestones in country. A note on country and regional issues can be found in Annex C, and summary reports of findings from the country visits, in Annex D.

Acknowledgements

The evaluation team is hugely indebted to the very many people around the world who gave so freely of their time and contributed so thoughtfully to the evaluation. We are immensely grateful to all those in Afghanistan, Brazil, Cambodia, Indonesia, the Russian Federation and South Africa who enabled the country visits to take place so effectively and at such short notice. Particular thanks go to the members of the Evaluation Steering Committee and above all to the Secretariat who bore the brunt of our detailed enquiries.

LIST OF INTERVIEWEES

Global

Stop TB Coordinating Board Members

Dr Ernest R. Loevinsohn (Chair of Board)	CIDA
Dr Gijs Elzinga	Chair, Working Group on TB and HIV/AIDS
Dr Mario Raviglione	WHO Recently Chair, Working Group on DOTS Expansion
Dr Kai Vink	Chair, Working Group on DOTS-Plus for MDR-TB
Dr Maria Freire	Chair, New Drugs Working Group CEO, Global Alliance for TB Drug Development
Professor Francis Omaswa	African Region Director-General of Health Services, Uganda
Dr Roberto Tapia Conyer	American Region Vice-Minister of Health, Mexico
Mr Ejaz Rahim	Eastern Mediterranean Region Federal Secretary of Health, Pakistan
Dr Jaap F. Broekmans	European Region Director, Royal Netherlands Tuberculosis Association (KNCV)
Dr Toru Mori	Western Pacific Region Director, Research Institute of TB (RIT), Japan Anti-tuberculosis Association, Tokyo
Dr Kenneth Castro	Centers for Disease Control
Dr Nils Billo	International Union Against Lung Diseases , Executive Director
Dr Jim Rankin	Management Sciences for Health (MSH) Director, Center for Pharmaceutical Management
Mr Christopher Lovelace	World Bank
Mr Rob Hecht	World Bank
Mr Alistair Robb (for Dr Julian Lob-Levyt)	Dfid, UK
Dr Anne Petersen	USAID
Dr Irene Koek	USAID Chief, Environmental Health and Infectious Diseases Division
Dr Jarbas Barbosa da Silva (for Humberto Sergio Costa Lima)	Secretario de Vigilancia em Saude Health Surveillance Unit Ministry of Health, Brazil
Dr Takeshi Ken Kasai	WPRO Regional Office - Manila

Working Group Secretaries

Dr Ulrich Fruth	TB Vaccines
Dr Leopold Blanc	WHO Secretariat Focal Point Coordinator - TB Strategy & Operations (TBS) HIV/AIDS, Tuberculosis and Malaria Cluster (HTM)

Dr Paul Nunn	WHO Medical Officer TB Strategy & Operations HTM
Dr Mark Perkins	New Diagnostics – Secretarial Focal Point Scientific Director
Dr Rick O'Brien	CDC Secretariat Focal Point Division of Tuberculosis Elimination Centres Disease Control/Prevention

Partnership secretariat

Dr Marcos Espinal	Executive Secretary
Dr Jacob Kumaresan	Ex-Executive Secretary of the Stop TB Partnership
Dr Petra Heitkamp	Stop TB Partnership Secretariat
Dr Sarah England	Stop TB Partnership Secretariat
Mr Philip Hopewell	Stop TB Partnership Secretariat
Ms Virginia Arnold	Stop TB Partnership Secretariat
Mr Michael Luhan	Stop TB Partnership Secretariat
Mr Satya Sarkar	Stop TB Partnership Secretariat
Dr Ger Steenburg	Stop TB Partnership Secretariat
Ms Lina Abraham	Stop TB Partnership Secretariat
Mr Robert Hernandez	Stop TB Partnership Secretariat
Ms Shalu Rosario	Stop TB Partnership Secretariat
Ms Valerie Diaz	Stop TB Partnership Secretariat
Ms Jillian Reichenbach	Stop TB Partnership Secretariat
Mrs Mary Meehan	Stop TB Partnership Secretariat
Ms Sulo Roy	Stop TB Partnership Secretariat
Ms Winnie de Guzman	Stop TB Partnership Secretariat
Ms Luz Baclig	Stop TB Partnership Secretariat
Ms Hanah Twal	Stop TB Partnership Secretariat
Mr Tom Moore	MSH, ex-seconded to Secretariat
Mr Robert Matiru	Stop TB Partnership Secretariat
Ms Diane Weil	Secretariat seconded (50%) to World Bank Human Development Department
Mr Finlay Craig	Consultant to STBP on resource mobilization
Mr Fahad Riahi	McKinsey GDF evaluation team

WHO

Ian Smith	Director-General's Office / ex-GDF Manager
Chris Dye	Stop TB Dept
Dermot Maher	Stop TB Dept
Brian Williams	Stop TB Dept
Katherine Floyd	Stop TB Dept
Georgia Galazoula	Stop TB Dept Finance Officer
Arata Kochi	Former head of TB, WHO
Tom Topping	Legal Adviser
Hilary Wild	Financial Controller
David Nolan	HR division
Alan Findlay	MSU Personnel
Richard Laing	Essential Drugs Management
Yves Bergevin	Medical Officer, RBM

WHO Regional / Country TB advisers

Dr E. Nyarko	AFRO TB Regional Adviser
Dr Rodolfo Rodriguez Cruz	AMRO Acting TB Regional Adviser
Dr Pilar Ramon	AMRO TB department
Dr Richard Zaleskis	EURO TB Regional Adviser
Dr Jai P. Narain	SEARO Coordinator, HIV, TB and other Communicable Diseases
Dr Dong Il Ahn	WPRO Regional Adviser, STB and Leprosy Elimination
Dr Maarten Bosman	WHO Medical Officer, Viet Nam
Dr Daniel Chin	WHO Medical Officer TB, China

Other Partners

Roy Widdus	Initiative on Public-Private Partnerships for Health Global Forum For Health Research
Kraig Klaudt	Massive Effort Campaign
Francesca Boldrini	World Economic Forum
John Tracey	Procter & Gamble
Patricia Carlevaro	Eli Lilly
Giorgio Roscignio	FIND
Susan Bacheller	USAID
Ms Fran du Melle	American Lung Association
Joanne Carter	RESULTS
Edward Tschan	American Red Cross
Matt Chico	American Red Cross
Francois de la Roche	American Red Cross
Paul Robinson	American Red Cross
Mary Linehan	PATH
Professor Lee Reichman	Executive Director, National TB Center, New Jersey, USA
Christine Whalen	MSH Boston

Other Global Health Partnerships

Tore Godal	GAVI Executive Secretary
Umberto Cancellieri	GAVI Secretariat
Bo Stenson	GAVI Secretariat
Lisa Jacobs	GAVI Secretariat
Vinand Nantulya	GFATM Secretariat
Brad Herbert	GFATM Secretariat
James Banda	Roll Back Malaria
Bruce Aylward	Polio Eradication Initiative
Jennifer Linkins	Polio Eradication Initiative

COUNTRY VISITS

Russian Federation

Ministry of Health

Professor Anatoliy Vialkov First Deputy of the Minister of Health
Dr Natalia Antonova Head of Division for Organisation of Medical Care of Infectious Diseases, Health Care Organisation and Development Department

Ministry of Justice, Medical Department of the Corrections Directorate (GUIN)

General-major Alexander Kononets Head of GUIN
Dr Svetlana Safonova Chief TB Specialist, GUIN

Central TB Research Institutes (CTRI), Russian Academy of Medical Sciences

Professor Olga Demikhova Deputy Director of CTRI
Professor Vladislav Erokhin Director of CTRI
Professor Viktor Punga Head of Organisational Research Department, CTRI

Research Institute of Phthisiopulmonology (RIPP)

Academician Mikhail Perelman Chief TB Specialist, Ministry of Health / RIPP Director, Sechnov Moscow Medical Academy

Orel Oblast

Dr Tatyana Harasheva Assistant to Head of Oblast TB Department
Ms Alla Ivanovna Red Cross, The Russian Federation
Dr Boris Kazionniy Head of Oblast TB Department
Dr Oleg Polyakov TB Doctor, Orel Prison
Dr Mikhail Shirokov Head of Department of Health, Orel Oblast
Dr Elena Kirianova Deputy Head Physician on Surveillance, Oblast TB Dispensary

World Health Organisation

Mr Alexander Egorov Personal Assistant, WHO TB Control Programme
Dr Wieslaw Jakubowiak Coordinator of the WHO TB Control Programme
Mr Konstantin Malakov TB Assistant, NPO, WHO TB Control Programme
Ms Olga Oleinik Secretary, WHO TB Control Programme
Dr Dmitriy Pashkevich TB Assistant, NPO, WHO TB Control Programme
Dr Mikko Vienonen Special Representative of Director-General in Russia

International Federation of Red Cross and Crescent Societies

Ms Vlada Chugaeva Manager Assistant, IFRCCS
Dr Per Jensnaes Head of the Russian Delegation, IFRCCS
Dr Elena Klotchkova TB Medical Assistant, IFRCCS
Dr Yuri Kokotov TB Medical Officer, IFRCCS
Dr Zlatko Kovac TB Programme Manager, IFRCCS

Partners in Health, Representative Office in the Russian Federation

Ms Oksana Ponomarenko Head of Moscow office
Ms Ekaterina Goncharova Medical Research Program Director
Dr Irina Gelmanova Project Coordinator
Mr Michael Nikiforov Technical Assistant
Mr Alexey Prorekhin Deputy Director on Administrative Issues

Other international agencies

Dr Gustavo Aquino Health Advisor, Centres for Disease Control and Prevention

Dr Pedro Chequer	UNAIDS Representative in the Russian Federation
Dr Sylva Etian	Deputy of USAID / Russia's Health Office, USAID, The Russian Federation
Ms Tatiana Loginova	Health Operations Officer, Social and Human Development Programmes, Russia Country Department, World Bank
Dr Bethanne Moskov	HIV/AIDS Advisor, USAID, The Russian Federation
Ms Elena Pushkareva	Health Policy Advisor, Development Section, DFID, Russian Federation

Secretariat of the High Level Working Group on TB in the Russian Federation⁸

Dr Svetlana Sidorova	Chief TB Specialist, Medical Department, Directorate of Corrections of the Ministry of Justice of the Russian Federation
Ms Irina Danilova	Programme Assistant, WHO TB Control Programme, the Office of the Special Representative of the WHO Director General in Russia
Ms Ludmila Rybka	Programme Assistant, WHO TB Control Programme, the Office of the Special Representative of the WHO Director General in Russia
Dr Nana Gvetadze	Senior Research Fellow, CTRI
Mr Lev Kapkov	Senior Research Fellow, Head of the Department for Processing Medical and Statistical data, CTRI
Dr Sergei Popov	Head of Laboratory, RIPP
Dr Elvira Putova	Senior Research Fellow, Organizational and Methodical Department, CTRI

Cambodia

Ministry of Health

Dr Mam Bunheng	Secretary of State for Health, Cambodia
Professor Eng Huot	Director General of Health
Dr Lo Vesana Kiry	Deputy Director, Planning
Dr Taing-Se	OD Chief, Tacmar District, Kandal
Dr Yath Thoeum	Kandal
Ms Thawvry	Deputy Director, Budget, MoH
Dr Mean Chhi Vun	Deputy Director General of Health and Director, National AIDS Programme

National Center for TB and Leprosy Control (CENAT)

Dr Khun Kim Eam	CENAT
Dr Mao Tan Eang	Director, CENAT
Dr Saint Saly	Chief, Research, Training and Supervision, CENAT

World Health Organisation

Dr Pratap Jayavanth	Medical Officer, Stop TB, WHO
Dr Jim Tulloch	WHO Country Representative

Other international agencies

Dr Chak Chantha	Development Assistance Specialist, USAID
Mr Jean-Francois Fry	Executive Director, MEDICAM
Ms Kristina Mitchell	Health and Nutrition Initiatives Fund Coordinator, CIDA
Dr Chawalit Natpratan	Country Director, FHI
Dr Kosuke Okada	Chief Advisor, JICA TB Control Project
Dr Okusho Onazaki	Consultant, JICA TB Control Project

⁸ not met individually

Mr Steven Navon	Senior Operations Officer, World Bank
Schonberger	Director, Country Cooperation Office, CIDA
Mr A. F. Sarkar	Country Programme Advisor, UNAIDS
Ms Geeta Sethi	MEDICAM
Mr Sin Somuny	Chief, CDC Cambodia
Mr Jack N Spencer	

South Africa

National Health Department

Dr Thuthula Balfour	Director International Health Liaison
Dr Refiloe Matji	Director National TB Programme
Dr Lindiwe Mvusi	Principal Medical Officer National TB Programme
Mr Pumlanzi Ximiya	Communications Officer National TB Programme

Cape Town City Health

Dr Virginia Azevido	Principle Medical Officer City of Cape Town
Ms Judy Caldwell	Coordinator TB Programme Western Cape Region of Provincial Health Services
Dr Ivan Toms	Head of Health, City of Cape Town

International Agencies

Mr Kevin Bellis	Management Advisor DFID
Mr Bill Coggin	Health Advisor CDC
Ms Paula Maketsi	Coordinator SATCI
Dr Welile Shasha	WHO Liaison Officer

Country NGOs

Ms Ria Grant	TB Care
Ms Lisa- Marie Smith	TADSA
Dr Shereen Usdin	Soul City
Dr Karin Weyer	TB Programme Medical Research Council South Africa

Indonesia

Ministry of Health, Directorate General CDC & EH

Dr Carmelia Basri	Senior Medical Officer, NTP Programme
Dr Rosmini Day	NTP Manager
Dr Haikin Rachmat	Director, DTDC

Jogjakarta district visit

Budiyono	Sub-District P2 TB
K Chandra	Chief of Gedongtengen Sub-District Health Centre
Iswanto	Dinkes Prop District Jogjakarta
Roni Naning	Pediatrician (DOTS Committee)
Ning Rintiswati	Microbiologist
Riyanto	The Indonesian Association Against TB
Suhanra	Dinkes Prop District Jogjakarta
Susilawati	Dinkes Prop District Jogjakarta
Sri Retno Irawati	Pediatrician (DOTS Committee) Hospital Association
Sri Wulaningsil	District Health Centre (DOTS Committee)
Yoworohaizi	Dinkes Prop District Jogjakarta
Ywruwual	DOTS Committee

Panti Rapih Hospital, Jogjakarta

Dr Andry Hartono	GP, Panti Raiph Hospital
Dr Iswanto	Pulmonologist, Panti Raiph Hospital
Laksmita	Laboratory Technician, Panti Raiph Hospital
Elisabeth Retno Lestari	Nurse, DOTS Corner, Panti Raiph Hospital
Dr Kartomo	Chief of TB Team, Panti Raiph Hospital
Markus Siryo	Medical Records Unit, Panti Raiph Hospital
J.H.Suei	Chief of Inpatient Unit, Panti Raiph Hospital
Dr Trijoko	Chief of Laboratory, Panti Raiph Hospital
Emma Widuriningsih	Nurse, DOTS Corner, Panti Raiph Hospital

World Health Organisation

Ms Sarah Barber	Donor Coordination / Health Systems
Dr Roosyana Hasbullah	WHO Consultant
Dr Franky Loprang	National Professional Officer (TB)
Dr Firdosi R.Mehta	Medical Officer (Tuberculosis)
Dr Georg Peterson	WHO Country Representative

Other international agencies

Ms Mary Leangkong	Representative, World Vision Indonesia
Ms I.E.S.Dwiartini	Financial Specialist, ICDC (ADB programme)
Dr Michael Kimerling	Associate Professor, Gorgas TB Initiative, University of Alabama at Birmingham
Dr Eddy Lamanepa	Technical Coordinator, ICDC (ADB programme)
Dr Erik Post	Representative for Indonesia, NLR
Dr Jonathan Ross	Public Health Advisor, HIV/AIDS & Infectious Diseases Team, Office of Health, Population & Nutrition, USAID
Dr Marion Steentjes	Regional Medical Officer, NLR
Mr Hideharu Tachibana	Assistant Resident Representative, JICA
Ms Peggy Thorpe	First Secretary (Development), CIDA, Canada
Dr Jan Voskens	Senior Consultant, KNCV

Agencies at the TB Partners Forum Meeting

USAID, CIDA, NLR, KNCV, World Vision, WHO, JICA, IMC, FHI, HOPE, WB, Gorgas TB Initiative, PCI, PWC, PPTI, PPTI-Jakarta, Coalition for Healthy Indonesia

Brazil

Ministry of Health (Secretaria de Vigilancia em Saude - Heath Surveillance Unit)

Dr Jarbas Barbosa da Silva Jr	Secretario de Vigilancia em Saude
Ms Adriana Bacelar	Data analyst, Area Tecnica de Pneumologia Sanitaria
Dr Ricardo Angnio Barcelos	Director, Departamento de Assistencia Farmaceutica e Insumos Estrategicos
Ms Ivanize Cunha	TB Nurse, Area Tecnica Pneumologia Sanitaria
Dr Miguel Aiub Hijjar	Director, Centro de Referencia Prof. Helio Fraga
Dr Expedito Luna	Director, Departamento de Vigilancia Epidemiologica
Ms Rosalia Maia	Assessora Tecnica, Area Tecnica de Pneumologia Sanitaria
Dr Carmen Lucia Muricy	Epidemiologista, Area Tecnica de Pneumologia Sanitaria
Dr Joseney Raimundo dos Santos Pires,	Director, Coordenacao Geral de Doencas Endemicas
Ms Ana Lucia Sarmento	Laboratorio Central de Saude Publica DF / Representative of Coordenacao Geral de Laboratorios de Saude Publica

Health Centre Number 1

Dr Maristele dos Reis Luz Alvez Health Secretary for TB Programme, Federal District

Ms Maria Candida Motta de Assis Nurse, Area Tecnica de Pneumologia Sanitaria

Ms Ildenei Reis de Oliveira TB Specialist Nurse, Health Centre No.1

Dr Mario Alberto Vidal Pessolani TB Specialist Doctor, Health Centre No.1

Pan-American Health Organisation / World Health Organisation

Dr Luis Gerardo Castellanos Coordenador da Area de Prevencao e Controle de Doencas

Dr Ademir Alberque Gomes Medical Officer, Tuberculose Control

Other international agencies

Ms Vincenza Lorusso Representante da Fundacao Damien, Conselheira Medica

Ms Patricia Paine HIV-AIDS/TB Technical Advisor, USAID Brazil

Health and Child Survival Fellows Programme

Afghanistan

Ministry of Health

Professor Akhgar Director General of Provincial Health

Dr Abdullah Fahim Director General of Health Care and Prevention

Dr Haidari Deputy NTP Manager

Dr Khaled NTP Manager

Herat

Dr Hamidi Deputy Regional TB Coordinator

Dr Rasooli National Health Coordinator WHO, Herat

World Health Organisation

Dr Keiko Inaba Medical Officer, Stop TB

Dr Giampaolo Mezzabotta Project Manager, Stop TB

Dr Moussa OIC

Other international agencies

Mr Firouz Afrouz Local Fund Agent Representative, Afghanistan

Mr Tamim Asey Development Officer CIDA

Mr Yoshiyuki Hashimoto Health Sector Programme Officer JICA

Ms Mariko Minamikawa TB Control Programme JICA

Mr Eric Sinclair Country Director, Medair

Ms Ellen Stamhuis TB Project Manager, Medair

Mr Inoue Takashi TB Project Coordinator, TB Control Programme, JICA

ANNEX C: THE GLOBAL STOP TB PARTNERSHIP AT COUNTRY AND REGIONAL LEVEL

Summarizing the issues arising from country visits to Afghanistan, Brazil, Cambodia, Indonesia, The Russian Federation and South Africa and interviews with some Regional and Country TB Advisers. Visits were undertaken by teams of 2-4 from 16 August – 3 October.

1. INTRODUCTION

While a global partnership against TB has been evolving for over a decade, it is the 2000 Amsterdam Ministerial Conference on TB and Sustainable Development, which seems to have catalysed significant extra effort in global TB control in a number of areas:

- a. **Political Commitment:** There is a far greater awareness of the seriousness of the tuberculosis epidemic and greater recognition that something effective can be done. TB control is reported to be much higher on the political agenda of countries visited than it was three years ago. The DOTS strategy has been accepted as the way forward, strategic plans developed in all but one of the 22 high burden countries, and significantly increased resources have been mobilised for implementation. Some key respondents viewed the Peer interaction at Ministerial and senior administrator level to be a more important ingredient for change than being part of international meetings.

Expert opinion and information from country programmes, data limitations acknowledged, suggests that the Stop TB Partnership is making significant progress, even in difficult environments. It was noted that while the DOTS strategy has been introduced into 158 out of 210 countries containing 98% of the TB patients, DOTS covers only one third of these patients. Strengthening health systems and human resources were seen as crucial to expanding DOTS effectively.

- b. **Partnerships:** Stronger partnerships are being developed at country level, with a much broader consensus on what needs to be done and how it should be tackled. The Stop TB Partnership goals are being regarded as the basis for policy, plans, technical assistance, TB drugs and other support. At least at national level the debate about DOTS seems to have moved from the question of “What?” to the question of “When?” Afghanistan, Cambodia, Indonesia and Russia have ICCs / or Partner Forums. Brazil and South Africa have informal partner coordination mechanisms in place. All countries have influential technical working groups in which partners are involved.
- c. **The Global Drug Facility (GDF) and the Green Light Committee (GLC):** At Regional level, the GDF and the GLC are seen as important interventions which improve access to good quality, inexpensive drugs and to strengthen DOTS. Cambodia had submitted an application to the GDF in August 2003 and Afghanistan is currently working on a proposal. In Indonesia GDF has been working with local TB drug manufacturers and an assignment of fixed drug combinations has been received via WHO. Though the other 3 countries visited have not used the GDF, in the Russian Federation the GLC has greatly improved access to second line drugs, and partly as a result of GLC activities there is Public Private Partnership aiming to produce cycloserine in South Africa.

The perceived threat to local manufacture of TB drugs, the need for a supplier to register the drugs and have a legal presence in the country and import tariffs seem to have limited the use of the GDF in countries like Brazil, Russia and South Africa which do not qualify for grants, but could benefit though improved procurement and quality procedures, and greater use of fixed drug combinations.

2. RELEVANCE OF THE PARTNERSHIP

As responses to the pandemic at international and national level form a continuum, it is difficult to dissect out the effect of the Partnership per se. However, from available documentation and consultations at country level and with Regional TB advisors, it is clear that over the past few years tuberculosis and its effective control have been given a much higher priority in all the countries visited.

- a. The Amsterdam Conference on TB and Sustainable Development in March 2000 involving Cabinet Ministers from 20 of the 22 High Burden countries (HBC) seems to have been a watershed as far political support for TB control in at least four of the countries visited. In Brazil and Afghanistan the process has been slower. In Brazil because the TB programme is almost fully funded out of the Government Health Budget and Afghanistan because of political turmoil in the last decade. Following recent political change in both these countries, far greater priority is being given to the policy and coordination needed to implement the DOTS strategy.
- b. With the launch of the Stop TB Partnership, those working in TB Control programmes at national and international level have felt that DOTS is far less a "WHO TB Programme" and there is a more a sense that in StopTB, "we are in this together".
- c. It was noted at Regional level that the Stop TB Partnership has also brought TB control out of its medical box by stressing important issues such as development, poverty and gender and noted that the Partnership had been instrumental in adding TB control to the United Nations MDG indicators.
- d. Generally the Stop TB logo is well recognized, though sometimes missing on country IEC material and documents obviously influenced by the work of the StopTB partners.
- e. Understanding of the role of the Global Stop TB Partnership is less evident. Some interviewees at national and regional level did not believe this to be a problem. What was important was that StopTB had enabled Partners to work much more closely together.

"It is true that the work of the Partnership is not always recognized at country level. Countries do not necessarily see the additional funding as something originating from or facilitated by the Global Partnership. This should be of minor importance. Through its advocacy and funding mechanisms, the Partnership facilitates the TB control work that is implemented at country level. "

- f. A number of interviewees felt encouraged that serious attention was being paid to new tools as these were seen to be the ultimate keys to solving the TB problem.

3. EFFICACY

In all six countries in the past three years, there has been substantial improvement in political attention and policy development being paid to tuberculosis as major public health and economic challenge. It was recognised that the excellent programme development work undertaken by various partners especially WHO had been vital and that recent country political change has also played a role. However several interviewees in different countries thought that it was bringing together Ministers and senior officials from different countries together to listen and talk to one another about TB control that was the key that opened that door to this process - especially in the larger countries visited. It was also recognised that there were major barriers in moving from political and policy change to effective wide spread implementation.

- a. Policy change benefits are the development of the Medium Term Plans, new TB control policies and TB drug regimens more in line with the DOTS strategy, by the formation of technical working groups, by new NGO activities, the upgrading of laboratory services, drug quality assurance processes and programme information documentation. Changes in Brazil and the Russian Federation especially are reported.
- b. Financing: It was reported in a number of countries that funding for TB had increased in recent years, but it was not possible to verify this. Concerns remain over whether funds from external sources are additional or substitutional. It was difficult to ascertain in the countries visited the trends in funding for the TB programme, largely due to decentralization initiatives and the range of funding sources for TB, including national government, state / regional governments, district / municipalities and external donors. In Brazil, Russia and South Africa, governments generated the vast majority of programme funds and partners provided important technical assistance and funding which helped catalyse useful activities
- c. Information on Programme Effectiveness: While it was not in the brief of this evaluation to evaluate programme information systems, reasonable data are essential to the proper functioning of the Stop TB Partnership. Interviewees at national level reported that more often than not, those involved at sub-national level take little interest in the data they process and do not receive meaningful feedback. Concerns were expressed by key informants in five of the countries, (Afghanistan, Brazil, Indonesia Russia and South Africa) about the quality of programme data at sub-national levels despite efforts at improvement. This is a well-known problem for many countries and the technical partners involved (WHO, KNCV, CDC and IUATLD) are generally following the course of ongoing feedback, encouragement, advising on systems and building technical skills.

In Cape Town, a three monthly meeting of facility managers and district TB coordinators to check register data, and complete and discuss quarterly reports together, has worked well . These meetings helped facility managers to improve programme information and develop problem-solving skills so that the majority of facilities and districts are achieving close to or better than 80% cure rates. In other areas it may be more feasible for the district coordinator to demonstrate how accurate register data and the quarterly reports can be used to problem-solve and improve TB programme outcomes.

4. EFFICIENCY

That the Stop TB initiative and the DOTS strategy has dramatically helped to improve TB control does not seem to be in question in the countries visited. The challenges lie in scaling-up of the operations and their long-term sustainability. The barriers that to turning policy change and initial acceptance into something more enduring are thought primarily to relate to health systems including health information, budget information systems, human resources, the process of decentralization, and closer cooperation between other disease control programmes such as Leprosy and HIV/AIDS. Noting that appropriate and effective implementation of the Stop Tb including the DOTS strategy can greatly facilitate Health sector development.

- a. Medium term / 5 year strategic plans have been developed in each of the countries visited. These plans have helped to clarify priorities, coordinate activities, promote cooperation of partners and motivate action in line with set targets.
- b. Technical support: Appreciation was expressed for the excellent technical guidelines; information and advocacy documents produced by the Stop TB working groups. Documents relating to DOTS expansion, HIV/TB and MDR TB were especially useful.

- c. Country support visits by members of the Stop TB Partnership especially were seen as a great help technically, to build morale and support advocacy efforts. Visits by staff from CDC, IUATLD, KNCV and WHO were specifically mentioned.
- d. Involvement of the 22 HBCs in the DEWG has also been an important developmental process. Although one participant felt that the gap between the energy and enthusiasm at the meetings and facing reality at home tended to be a bit discouraging.
- e. Regional meetings and training courses involving TB Programme staff from HBC and non HBCs, NGOs and Partners provided opportunities for inter-country synergies and support, peer learning, relationship building and networking and problem solving. For example in SEARO, partners set up mock Technical Review Panel committees to evaluate and strengthen proposals on TB control being sent to the GFATM.
- f. Advocacy, Communication and Social Mobilization: Both at country level and at the meeting of the Stop TB Advocacy and Communications Task Force meeting in Johannesburg 7-9 September, the need was expressed for a much greater effort in relation to advocacy, communication and social mobilization also at country level. The budget for advocacy was very small in relation to the need to significantly scale up public awareness, social mobilization and community participation, partnerships including public private ones, case finding, cure rates, etc
 - o All countries visited organised major TB advocacy activities around World TB day, although a number of interviewees expressed reservations about the value of the return on effort after seven such annual events. Some TB managers at the Johannesburg meeting reported that preparing for World TB day became their main activity for about 3 months of the year. The need for a higher advocacy and communication profile during the year was recognised but in no country, represented at the meeting or visited, did this seem to be a significant activity. It was felt that in all countries that the StopTB partnership had a much greater role in strengthening country communication and advocacy efforts both from both a technical and financial point of view. In other countries World TB Day was still seen as the one opportunity to get national political involvement.
 - o At the Advocacy and Communications meeting, there were pleas for more attention to be given to social mobilization at country level. Community Radio and cooperation with Poverty Reduction Programmes seem to be areas worth exploring.
 - o Also at this meeting there were clear tensions between those advocating for the urgent massive need for short term funding for DOTS expansion and the GDF and those advocating for substantial longer-term investment in new tools.
- g. Funding: It was reported that Partner funding had helped catalyse and in some cases directly fund all the activities above.

"In the Western Pacific Region funding has increased substantially as well, not only in high burden countries, while local and regional human capacity has been strengthened."

It was the experience of a senior WHO Advisor that many countries found it difficult to manage more than a certain amount of external funding. This was echoed by a Regional TB Advisor in EMRO:

"Is it really useful to have all these bodies/initiatives/etc and continue writing proposals all the time instead of simply putting the money in TB channel were it could flow directly to the countries and regions according to their strategic plans? I think the second road is

more logic (sic) and it does not contradict with the presence of the partnership or its efforts and effect. Also it could be useful to have a database of basic information of tuberculosis control programme in each of 22 high burden countries that could be used by any donor/initiative etc. to minimize the time spent on reports/proposal writing at country level.”

In the Afro Region, funding from Stop TB partners had increased and new partners such as the Italian Government and the Red Cross were now supporting Tuberculosis Control. The TB Control budgets of a number of countries were reported to have increased significantly. Specific mention was made about the value of the GDF in encouraging government support by the Regional TB advisor.

Similar trends were reported by staff involved in the Euro, SEARO and PAHO Regions.

Reservations were expressed in Brazil and South Africa about external funding for large projects, which were not well coordinated with the national programmes and services in the field. This had led senior government decision makers, who felt they were making a sincere attempt to work closely with StopTB, to question the insight or agenda of the funders.

One country TB Programme manager expressed some frustration with trying to balance the time taken up by high profile Stop TB partner and the time needed for more mundane and often difficult country programme support activities.

5. SUSTAINABILITY

In contrast to many other public health programmes, Stop TB is at country level is seen as one where real success can be achieved. There is a clear strategy with measurable goals, backing from major technical and donor agencies, widespread political acceptance and a number of countries are demonstrating success. And there also seemed to be good prospects of more effective tools in the not too distant future.

One experienced Regional adviser said that successful country TB programmes where there was substantial external support might not be sustainable when this support fades or government commitment has not keep pace with the growth of the programme.

“There has been tremendous growth of global partnerships in recent years. Though global advocacy has resulted in increased resources there are clearly a number of risks:

- *What will happen when global resources decline and existing multi or bilateral arrangements have expired?*
- *Global resources are clearly linked to political agendas. So the selection of countries may be influenced.*
- *Global resources may replace existing development assistance arrangements.*
- *Global resources may make some countries more dependent.*
- *Ownership of the development agenda is more difficult as the global partnerships tend to impose mechanisms on countries*
- *There is a clear problem of the capacity of some countries to absorb the huge amounts of funds which suddenly become available.”*

The following comments were also made:

“It is important to create national Stop TB partnerships, representing the local stakeholders and partners of civil society, NGO's etc. The GF is trying to do this through the CCM's.

However experience in (some countries), is not so positive. The main risk of the global partnerships is that nations will start relying on them too much. There are certainly the issues of sustainability and ownership which need to be addressed by the partnership(s). So the main question is how the partnership can stimulate countries to invest more in TB control using their own resources.”

To meet the challenges to expand DOTS and to strengthen health services, it was suggested that improving the understanding and the skills needed to initiate and maintain productive partnerships especially at field level. Such efforts should be linked to the strengthening of communications, social mobilization and advocacy capacity.

One interviewee felt that DOTS tended to be a top down approach. The question then arises, if more partnership is envisaged, has the time not come to talk more about the Stop TB and less about DOTS?

In response to the question “What do you see as future challenges facing StopTB?” Country and Regional Interviewees listed very similar issues: HR development; Health Info systems, Advocacy; Laboratory services; TB/HIV coordination; GFATM coordination; MDRTB; Quality Drug Supplies; Building country partnerships with all stakeholders.

6. RECOMMENDATIONS

Below are a summary of suggestions for considerations which came out of the discussions with interviewees and team members.

6.1 In balancing TB programme goals and country development needs, the StopTB Partnership should consider working with countries so that:

- a. TB control strategies are part of development and poverty reduction strategies.
- b. Sustainability issues are clearly addressed as outlined in the 2nd ad hoc Committee on the TB epidemic.
- c. Partner funding is increasingly channelled through direct budget support.
- d. Creative ways are found to minimise report writing by country programme staff. Donors should together develop a simple standard reporting format.
- e. Staff, management, planning and evaluation resources are coordinated with Malaria and AIDS programmes. Increased technical assistance may be necessary for proper management of these resources.
- f. Donor projects should be well coordinated with country and local services.
- g. Partners should as far as possible be included in annual country TB programme reviews which should include a strong qualitative reflective component to balance quantitative aspects. A senior health departmental decision maker should be encouraged part of such reviews. include a strong qualitative reflective component to balance quantitative aspects. A senior health departmental decision maker should be encouraged part of such reviews. Personal development for the TB programme manager should include support / encouragement to develop advocacy, networking, partnership building and time management skills.

6.2 The development of partnerships should be encouraged:

- a. At Regional level, STOPTB Partnership meetings should encourage country-to-country

learning and support should include non-HBC countries as well as NGOs, professional medical associations, political decision-makers and the private sector. Peer discussion should be encouraged to reduce misconceptions and encourage appropriate change. At this stage there does not seem to be an immediate need to replace the Partners Forum with Regional For a. Rather Regional partnership meetings should be piggy backed on existing international assemblies such as Regional Committee Meetings

- b. In Regions where progress is slow, the StopTB Partnership should provide leadership in those areas that needed strengthening.
- c. At national level partnership building skills workshops could be considered. Those with experience from other regions should be included as facilitators for such workshops.
- d. Brazil and South Africa should be encouraged to consider setting up Inter-agency Coordinating Committees / Forums
- e. At sub-national level, by improving the understanding of how partnership building could strengthen TB control (technically, administratively, politically and thro communications, social mobilization and advocacy)
- f. Internships, sabbaticals, staff exchange and secondments could be used as a creative interchange for staff renewal and development.
- g. The use of project teams with staff from different partners and stakeholders with their own budget, time frame and goals should be considered to deal with especially short term challenges or tasks.
- h. Advocacy, Communications and Social Mobilization The Stop TB partnership should consider the following issues which came up in country visits:
 - i. Communications and Advocacy capacity in the 22 high burden countries should be strengthened by technical assistance from partner agencies such as the Health Communication Partnership (John Hopkins University), the Rockefeller Foundation Centre for Communications for Social Change, Results, TB Alert and the Massive Effort Campaign. Opportunities should be sought in joint communications and advocacy efforts with the Global Fund for AIDS, Tuberculosis and Malaria.
 - ii. In the light of the comments received it may well be time to evaluate the ongoing impact and the direct and indirect costs of World TB Day and the usefulness of a single global message.
 - iii. Branding: increasing the use of Stop TB as a partnership concept in documents and reviews. IEC material. The Stop TB Logo should be visible on any IEC material and other publications linked to the Partnership. World TB Day: advocacy, communication and social mobilization at country level, beyond World TB Day.
 - iv. Advocacy and communications effort will need to be careful to balance the urgent need for short term funding for DOTS expansion and the GDF and in the longer term for investment in new tools.
 - v. Currently DOTS is the brand of the strategy and Stop TB the brand of the partnership / advocacy efforts. DOTS, while widely recognised, is still confused with DOT. DOTS is still seen by some as a top down approach and Stop TB is seen as something separate. This potential for confusion is compounded by the designation of WHO's own global programme as StopTB. Serious consideration should be given to shifting the branding of the whole programme to StopTB. DOTS could, for example, be referred to as the Stop TB strategy. This would also have the advantage of strengthening the concept of Partnership also at country level.

6.3 Country TB Programme staff should be encouraged to:

- a. Improve their own understanding of how partnership building at national and sub-national level, could help strengthen the implementation of the medium term plans and extend the effectiveness of TB programmes. See appendix: Steps to building Stop TB Partnerships at country level attached below.
- b. Consider holding national and sub-national workshops as outlined in 5.2 b. above. Develop, test and share ideas with current partners for expanding both partners and stakeholders. In countries where AIDS is a significant problem, this should include people working in the HIV/AIDS field
- c. Develop and keep up to date a Directory of country partners and stakeholders. This should include information on interests, dynamics, capacities and potential.
- d. Creative ways need to be found so that TB patients voices and opinions are heard at national policy and strategy meetings
- e. Ensure firstly a good understanding of health system funding, budgeting and accounting in general and secondly an ability to influence and monitor TB programme country budgets.
- f. Consider sustainability of each project undertaken with outside funding
- g. Find appropriate and creative ways to improve the value of TB programme data for those collecting it, supervising services and making management decisions at each level. For example by reporting key TB programme indicators at routine meetings at every level, peer reviews of data and recording and reporting systems at facility level, technical audits, etc. Any support should be aimed strengthening local capacity.
- h. Strengthen cooperation between TB and AIDS testing and treatment programmes especially in those countries where the majority of TB patients are also HIV positive. The Global Fund to fight Aids, Malaria and Tuberculosis, the fall in prices of Anti Retroviral drugs and the launch of the 3 by 5 initiative by the WHO Director General, open a new and vital window of opportunity to tangibly strengthen the partnership in this regard. Some members of the country TB ICCs should also be members of the GFATM Country Coordinating Mechanisms.

CONCLUSION

The Stop TB Partnership has made significant progress even in difficult environments in the past 3 years, by raising the political and socio-economic awareness of the impact and by improving financial and technical aspects of TB control at country level. The Partnership should continue to ensure consideration of the issues of stewardship, development, ownership and sustainability when initiating projects, and scaling-up and evaluating programmes.

The Stop TB Partnership has correctly focused on developing partnerships at regional and national level. In future, more emphasis should shift towards sub-national levels of the health services and to supporting operational issues. The TB/AIDS case load and health service decentralization will make this increasingly important in future.

Table 1: Reaching the Targets

Country	Afghanistan	Brazil	Cambodia	Indonesia	Russian Federation	South Africa
Population, 2002	27,963,000	174,485,000	12,487,000	211,716,000	144,071,000	43,580,000
GDP (US\$ mill), 2002	No data	452,387	3,677	172,911	346,520	104,235
Total notification, 2001	9,930	74,466	19,170	97,792	132,477	148,257
Global ranking, 2001	21	15	18	3	9	7
Estimated incidence /100,000 (total), 2001	314	64	585	271	134	556
Estimated incidence /100,000 (ss+), 2001	141	28	261	122	60	226
Case detection rate (total), 1998-2001	6-15%	82-78%	45-41%	12-21%	57-31%	90-85%
Case detection rate (DOTS), 1998-2001	6-15%	4-8%	45-41%	12-21%	1-5%	22-72%
DOTS coverage 1998-2001	11-20%	3-32%	100-100%	80-98%	5-16%	22-77%
DOTS success rate 1998-2000	33-86%	91-73%	95-91%	57-87%	68-68%	74-66%

Table 2 Stop TB Partnership Activities

5 year Plan	Draft	Yes	Yes	Yes	Yes	Yes
Country TB partnership structures	ICC	Informal	ICC	ICC	ICC	Informal
TB/AIDS Cooperation	N/A	Task Force	Pilot projects	Working Group	Working Group	Pilot projects
Global Drug Facility	GDF proposal in preparation	Own TB drug manufacture	Submitted proposal in Aug 2003	GDF working with country TB drug manufacturers. 1 assignment received via WHO	Own TB drug manufacture	Drugs bought out of own budget

Population and GDP data: World Development Indicators, World Bank, August 2003
Tuberculosis data: World Global Tuberculosis Report 2003, World Health Organisation

Appendix: Steps to building Stop TB Partnerships at country level

The main aims of the country level Stop TB Partnership are to:

- Support NTP to achieve national and global targets for TB elimination most rapidly and effectively, and to contribute to the overall national poverty eradication effort
- Situate and maintain TB high on the national and sub-national political and development agendas and thereby assure and sustain the appropriate level of political and financial support for the NTP.

The context must therefore be around the most appropriate existing structure or mechanism for Poverty Eradication in the country.

The following steps are proposed for action by the NTP Management or the TB ICC:

1. Undertake an update of the TB situation in the country in collaboration with the existing partners using existing data and information in the first instance.
2. Identify the existing national level mechanisms for coordinating the national poverty eradication effort (national Poverty Eradication Plan, MDG monitoring and coordinating mechanism, Poverty Reduction Strategy (PRS), CDF, etc).
3. Identify the most appropriate allies or potential allies within such a structure/mechanism (e.g. prominent member of the STB Partnership or active supporter of TB in the country - national and international officer).
4. Define as clearly as possible how the health sector articulates with such a body or structure (Who represents the health sector on such a body? Does the national poverty eradication plan have a strong health component? Does this specifically include TB and HIV/AIDS? Do the national poverty eradication monitoring indicators include TB or HIV? Etc).
5. Determine how effective the representation of TB is within the Ministry of Health itself. What is the level of government commitment to TB prevention and control?
6. Define the existing TB coordinating mechanism in the country (ICC for TB and or HIV/AIDS, CCM, health SWAp mechanism, MTEF, existence of a formal STB partnership. or nucleus for one, significant national TB project such as the WB MAP, etc)
7. Develop a strategy for achieving the most effective and sustainable STB partnership by systematically addressing gaps and deficiencies identified in the review, with special attention to the above.
8. Start with the establishment of an interim ICC if one not already available followed by a clear definition of the case for TB as a national priority.
9. Do not be too over ambitious in the beginning; it is for example not reasonable to aim for a direct TB specific representation on the national PRS coordinating body which is necessarily of limited membership. Look for a sympathetic ally instead such as WHO, WB, a bilateral, within the Ministry of Finance and Planning).
10. Size available opportunities for forging smaller TB partnerships at sub-national, district and community levels, but always bearing in mind that they fit into the overall strategy designed in 7 above.
11. Elicit the necessary support from the Global Partnership to STB for the development and implementation of an effective and sustained advocacy campaign for Stop TB. This must be clearly and separately targeted at key audiences such as the national government, sub-national and district governments, existing and potential partners, NGOs, PPMs, Private for Profit service providers, and especially to the communities. The latter, though most demanding in time and effort, is essential for achieving effective demand for services and influencing national political commitment to providing the necessary environment for effective access to quality TB programmes and services.
12. Do not bite more than you can chew at any one time. Be opportunistic and progressively on concrete and demonstrable successes, each success feeding into the chain of activities defined under the overall strategy formulated in 7 above.

ANNEX D: COUNTRY VISIT REPORTS

EVALUATION OF STOP TB PARTNERSHIP: RUSSIAN FEDERATION	
TORs	FINDINGS/EVIDENCE
1. Key trends in TB control 1999-2003	<p><u>General Environment</u> The partnership has been established in a difficult political environment, attempting to introduce new approaches in a system facing the major challenge of decentralisation whilst trying to maintain its existing infrastructure against a backdrop of declining resources. Broader economic and social changes in the Russian Federation have also posed major problems to the TB programme.</p> <p><u>Adoption of the Stop TB strategy has expanded coverage.</u> The Stop TB strategy has been adapted and built into the Russian TBCP.</p> <ul style="list-style-type: none"> • The Stop TB strategy has been introduced through the rapid roll out of a series of pilot projects. The number of TB pilot sites has increased from 1 (Tomsk Oblast) in 1994 to 26 regions by 2002 covering an estimated 26% (In July 2003) of the Federation's population (which is estimated at around 145.5 million in 1999/20000 (UNDP 2001)). • Treatment success rate remains low at 68%. This is due to high levels of treatment failure (due largely to high levels of MDR TB and interruption of treatment) and default (due largely to social and economic problems such as alcoholism, homelessness and unemployment). Case detection remains low: 31% nationally, of which 5% has been through Stop TB strategy (2001, WHO) <p><u>The prison population is particularly heavily affected, MDR-TB represents a major threat</u> Reported TB cases increased from some 124,671 in 1999 to 127,192 in 2001 though MoH estimates that cases subsequently declined to some 123,340 in 2002. 3,476 MDR TB cases were reported in 2001 - some 7% of total reported cases Almost 60% of reported cases in 2001 were in the prison population. 76,000 prisoners, of a total prison population of around 800,000, have active TB of which 16,000 cases are drug resistant and 6,000 are multidrug resistant. HIV prevalence remains low (173,068 HIV-infected persons were registered in January 2002) but the risk of rapid increase is high.</p> <p><u>Future Plans</u> Government's 5 Year Plan for TB control focuses on large scale implementation of the TB control strategy with emphasis on:</p> <ul style="list-style-type: none"> (i) defining strategy and strengthening monitoring and implementation of TB control at the federal level (ii) training and education at the federal level (iii) improvement of TB case detection and diagnosis (iv) improvement of TB patient treatment
2. Impact of the Stop TB Partnership on political commitment to Stop TB	<p>Increased political commitment at federal level in the Russian Federation from 1999 is demonstrated by:</p> <ul style="list-style-type: none"> i) <u>policy and legislative developments</u> <ul style="list-style-type: none"> a) TB Control Law No.77-03, 16.6.2001, 'On preventing TB dissemination in the Russian Federation' b) Resolution on implementing the Control Law 25.12.2001 c) Executive Order (Prikaz) No.109, 21.3.2003, 'On improvement of TB Services in the Russian Federation', stipulating new diagnostic, treatment and surveillance standards ii) <u>development of an operational plan for TB control</u> 5-Year Plan (Provision of Guaranteed Diagnostic and Treatment Procedures for TB Patients and Development of TB Service in Russia: Plan for 2003-2007) approved by High Level Working Group 14th May 2002. \$972m is required over 5 year period iii) <u>increased funding for TB control</u> <ul style="list-style-type: none"> a) There has been additional funding for TB control from the federal budget: Federal funding for TB through the Ministry of Health (MoH) and Ministry of Justice (MoJ) has increased as follows: <ul style="list-style-type: none"> 1999 809.6bn roubles 2000 883.9bn roubles

	<p>2001 1,171.2bn roubles 2002 1,304.2bn roubles 2003 1,468.2bn roubles (planned)</p> <p>In addition the regions cover salaries and other capital and recurrent expenses (fuel, food for patients, medications, communication etc). Total costs of TB control from all sources are estimated at around \$203m in 2002 (draft GFATM proposal, 2003). Despite the additional funding the 5 Year Plan still has a large financing gap estimated at \$474m (even allowing for b) and c) below) though it is anticipated that local Government may contribute some \$100m over the period and reduce the gap somewhat.</p> <p>b) approved World Bank loan for TB control (\$100m) and HIV (\$50m) between 2004 and 2007 supplemented by a Government contribution of some \$134.1m over the period</p> <p>c) application to the Global Fund (GFATM) for \$118.1m over 5 years at draft stage August 2003. The Stop TB Partnership Secretariat has provided useful inputs to the development of the proposal.</p> <p>iv) <u>high level participation of key stakeholders</u>, including from the Ministry of Health (MOH) and Ministry of Justice (MOJ), in partnership mechanisms, e.g. High Level Working Group and Secretariat; TB-ICC</p> <p>v) <u>TB a government priority</u>: TB is on the Russian Federation government's priority list; monthly reports on TB control are sent to the President from the MOH and MOJ.</p> <p>vi) <u>TB is a local priority</u> In Orel (visited by the evaluation team) TB is seen as the top health priority (alongside child health)</p>
<p>3. Impact on partnership building</p>	<p>Substantial partnership building from 1999, as demonstrated by:</p> <p>i) High Level Working Group established 1999; has met seven times (Membership is made up of MoH, MoJ, WHO, RAMS (CTRI), RIPP and Council Of Europe).</p> <p>ii) High Level Working Group Secretariat established January 2001</p> <p>iii) Over 12 Thematic Working Groups been established (some have completed activities)</p> <p>iv) TB-ICC and TB-ICC Advisory Board established September 2002. Advisory Board membership is made up of MoH, MoJ, Russian Academy of Medical Sciences (RAMS), WHO, 2 donor representatives and 4 representatives from technical agencies. The latter two categories currently comprise CDC, USAID, DFID, World Bank, Medecins sans Frontieres (MSF) and Russian Red Cross (RRC). Membership is subject to annual renewal</p> <p>v) monthly informal Interagency Meetings on TB including a range of technical partners</p> <p>vi) useful partnerships at local level – in Orel partnerships between local institutions - the TB dispensary, Prison Services, local Red Cross and regional TB doctors - have been supported by WHO and CDC.</p> <p>There is consensus that partnership activities have been meaningful and have helped to catalyse and sustain TB activities. The various fora include all relevant partners, except that UNAIDS - though invited – does not generally attend.</p> <p>GFATM proposals have not been developed in a collaborative manner (3 were developed separately by NGOs and RAMS and submitted for the 3rd round). Little is known about the NGO and research institute proposals within the partnership. The MoH is presently working on a separate proposal to be submitted in the next round.</p>
<p>4. Impact on TB awareness</p>	<p>i) Extensive activities for World TB Day since 2000</p> <p>ii) Stop TB allegedly known and widely recognised as a brand name, but not the Global Stop TB Partnership</p> <p>iii) Cooperation of the Oblast Health Department with NGOs such as Red Cross has led to school / business involvement and improved incentives for patients to access treatment</p> <p>iv) limitations in communications (see 5 below)</p> <p>v) Green Light Committee (GLC) support has increased general awareness about</p>

	appropriate use of second line drugs (see 5 below)
5. Impact on availability of high-quality anti-TB drugs	<p>i) Availability of drugs has improved given the allocation of additional federal funds, though significant problems still exist in terms of distribution and quality assurance.</p> <p>ii) Recent steps to transfer the main responsibility for purchasing drugs to the regions raise concerns about sustainability - and there is evidence from pilot projects that stock levels are declining though they are still generally at acceptable levels.</p> <p>iii) Provision (around \$40m) has been made for the purchase of drugs under the GFATM proposal and World Bank loan.</p> <p>iv) The Global Drug Facility (GDF) has not been utilised because its current portfolio of approved drugs does not include drugs registered for use in Russia. The process for securing such registration is time consuming. Even so competing pressures to support local pharmaceutical industry suggest use of this facility would be, at best, limited. One option is to assist local manufacturers to achieve GMP (Good Manufacturing Practice) status and be able to compete for GDF tenders though the ultimate responsibility for taking this forward rests with the companies themselves.</p> <p>v) The GLC has had a direct, though modest, impact providing second line drugs in some NGO-supported pilot project areas but not through the Government system. It has had a broader impact in terms of raising awareness about the appropriate use of second line drugs. Simplifying application procedures and the provision on management training could allow this mechanism to be utilised more effectively</p>
6. Issues	
Validity of the approach	There are still outstanding concerns within the Russia Federation about the validity of the Stop TB strategy and indeed use of the term DOTS itself
Attribution of impact uncertain	Clear evidence was found of increased political commitment and partnership activity since 1999. The WHO office was established in the Russian Federation in 1998, simultaneously with the launch of Stop TB Partnership. It is, therefore, impossible to distinguish Stop TB Partnership activities from those of the WHO office in Russia, so impact cannot be attributed with certainty. The greater impact is likely to rest with WHO. From a country perspective the need to distinguish between the impact of the partnership and WHO was not seen as important.
Advocacy and Communication	<p>Visits at both national and local level stressed the need for:</p> <ul style="list-style-type: none"> • efforts to strengthen advocacy efforts at the national level • strengthening cross-country learning • improving internet access, especially for materials in the Russian language • messages to encourage patients to take greater responsibility for care and prevention, especially those who refuse treatment <p>There are problems in engaging with patients groups (due to social stigma) and also problems with social mobilisation</p>
Implementation within a decentralised system	The regions have considerable autonomy in the allocation and use of funds. The fact that responsibilities for financing TB activities are now being passed to the regional level, without additional specified funds being made available to meet the associated costs, means advocacy efforts will assume major importance and will need to be targeted towards the regions rather than the centre
Stop TB roll-out is pilot project-based	The Russian TB programme has developed over many years with active case finding based on chest X-Ray diagnosis. The new pilot sites build on this system and help strengthen quality laboratory services and standard reporting systems. These pilots are helping build confidence in the new approaches and to support the Russian TB programme, especially in prisons, to identify the onset of disease in its early stages. Cost effectiveness studies are being undertaken to further improve the roll out of the programme. However, it is not clear that such a project based approach will be sustainable in the long term and that it will be feasible to roll the approach out to all regions.
Lack of resources	<p>Risks include:</p> <ul style="list-style-type: none"> • the lack of human and financial resources to accelerate the programme, • reliance on external sources in financing pilot programmes and • possible inability and/or unwillingness of regional authorities to provide adequate funds

EVALUATION OF STOP TB PARTNERSHIP: CAMBODIA	
TORs	FINDINGS/EVIDENCE
1. Background	<p>Basic data</p> <ul style="list-style-type: none"> • 24 provinces and Phnom Penh, 101 administrative districts, 74 operational districts • 12.5 million population, 15.7% urban population • TB services mainly through hospitals just started with health centres • CENAT- the national TB and Leprosy centre is responsible for implementation • WHO TB team comprises one International Medical Officer (joined June 2002) • 2 sources of TB funds – national recurrent budget (drugs and salaries) and donors <p>TB estimates</p> <ul style="list-style-type: none"> • Estimated incidence rate 540 new cases per 100,000 (variable estimates) • Smear positive pulmonary TB incidence rate 241 per 100,000 (1999) • CDR is around 30% (2002) <p>Main TB partners</p> <ul style="list-style-type: none"> • External: WHO, JICA, CDC, USAID, CIDA • NGOs: NGO coalition, FHI, MEDICAM <p>Stated NTP Priorities</p> <ul style="list-style-type: none"> • To ensure equity and access to TB services, and maintain a cure rate of over 85% • 5 Year Strategic Plan stated aim is also to achieve DOTS coverage of 58% by 2003, 79% by 2004 and 100% by 2005; and to achieve a CDR of at least 70% by 2005 <p>Chronology</p> <p>1993: TB Control programme integrated into hospital services. WHO started assistance</p> <p>1994: DOTS introduced in hospitals; WFP contracted to provide food supplementation for patients admitted in hospitals; cure rate increased substantially</p> <p>1995: DOTS evaluated; WHO recommended TA agency to build capacity and need for additional donor funds</p> <p>1995: National Committee for TB Control established with Honourable Prime Minister as Chair and Minister of Health as Co-chair</p> <p>1996: Annual National Conference started and held every year on World TB Day</p> <p>1997: World Bank supported Health Sector Reform Project provides funds for TB control</p> <p>1998: JICA committed to assist TB control</p> <p>1999: JICA project started; WHO and JICA assisted government to create a Partnership; Government decided to top-up salary for TB control staff as much as 100%</p> <p>1999: Quarterly meeting for monitoring and review established with PHD and ODs</p> <p>Sep 1999: DOTS implementation in 9 pilot health centres of 3 provinces</p> <p>2000: Minister of Health attended the Amsterdam Conference</p> <p>Oct 2000: DOTS implementation in 4 pilot operational districts.</p> <p>Oct 2000 – April 2001: National Drug resistance survey</p> <p>Jan 2001: DOTS implementation in capital</p> <p>Mar 2001: Inauguration of CENAT building (TB / leprosy control centre) funded by JICA</p> <p>April 2001: Establishment of Inter-agency Coordination Committee with Director of TB Control Programme as chair</p> <p>July – Nov 2001: The National Health Policies and Strategies for TB control (2001-2005); and the National Health Strategic Plan for TB Control (2001-2005)</p> <p>Sep 2001: Expansion of DOTS started to cover the whole country within 5 years</p> <p>Nov 2001: TB screening clinic for PLHA</p> <p>April – Dec 2002: National TB Prevalence Survey</p>
2. Key trends in TB control / DOTS strategy	<ul style="list-style-type: none"> • By 1999 all hospitals in Cambodia were covered by DOTS • Currently 64 out of 74 operational health districts provide DOTS • Substantial increase in DOTS coverage, CDR and cure rate from 1999 to 2002: coverage at health centres has increased from 0% in 1999 to 41% in 2002, CDR has

	<p>increased from 48% in 1999 to 69% in 2002; and cure rate up from 85% to 89%</p> <ul style="list-style-type: none"> • Pilot underway to link DOTS Programme with home based care for HIV/AIDS • No linking with prison services as yet 										
3. Impact of the Stop TB Partnership on political commitment to Stop TB	<p>Increased political commitment at national level in Cambodia from 1999, as shown by:</p> <p>a) policy and legislative developments:</p> <ol style="list-style-type: none"> i) National Health policies and strategies for TB control (2001-2005) approved by the Government in July 2001 ii) National TB Committee headed by Prime Minister and co-chaired by Minister of Health with members from provincial governors iii) Incorporation of TB control activities under Chapter 13 of the financial legislation. (Chapter 13 refers to the provision of free health care for patients for particular priority disease/conditions and also protected for budget allocation) iv) Key partners (WHO, JICA and CIDA) contributed funds for policy document formulation, production and dissemination. <p>b) development of plans and guidelines for TB control:</p> <ol style="list-style-type: none"> i) National Health Strategic Plan for TB Control (2001-2005) formulated and approved by the Government along with key partners ii) Framework for TB/HIV guidelines approved by the GoC <p>c) increased funding for TB control:</p> <ol style="list-style-type: none"> i) Government contribution increased by 90% in 1999 and almost 300% between 1998 and 2003: <table style="margin-left: 40px; border: none;"> <tr> <td style="padding-right: 20px;">1999</td> <td>708 mil Riel (\$0.17m)</td> </tr> <tr> <td>2000</td> <td>1339m Riel (\$0.35m)</td> </tr> <tr> <td>2001</td> <td>1560m Riel (\$0.40m)</td> </tr> <tr> <td>2002</td> <td>2153m Riel (\$0.55m)</td> </tr> <tr> <td>2003</td> <td>2530m Riel (\$0.63m)</td> </tr> </table> ii) JICA started new project on DOTS and other key funders increased contribution iii) Since 2002 by legislation TB treatment and diagnostic services are exempted. <p>d) High level participation of key stakeholders in partnership activities:</p> <ol style="list-style-type: none"> i) Minister of Health attended the Conference on TB and Sustainable Development; and First Stop TB Partners' Forum ii) Senior staff of TB including key partners (JICA and WHO) attended most international events iii) ICC for TB established and functional iv) TB/HIV Working Group established v) TB Manager part of the High level COCOM 	1999	708 mil Riel (\$0.17m)	2000	1339m Riel (\$0.35m)	2001	1560m Riel (\$0.40m)	2002	2153m Riel (\$0.55m)	2003	2530m Riel (\$0.63m)
1999	708 mil Riel (\$0.17m)										
2000	1339m Riel (\$0.35m)										
2001	1560m Riel (\$0.40m)										
2002	2153m Riel (\$0.55m)										
2003	2530m Riel (\$0.63m)										
4. Impact on partnership building	<ul style="list-style-type: none"> • High level ICC established in 2001 and meets regularly, mostly monthly • Increased number of NGOs are involved • Weekly informal interagency meeting on TB • Pilot testing of home-based TB care is conducted by NGOs • With support from CIDA, WHO focal point supports the Government in building capacity and partnership 										
5. Impact on TB awareness	<ul style="list-style-type: none"> • Three day annual TB conference held involving all levels of TB staff with the World TB Day – Rally, Mass and Electronic media and high level political participation • Wider mass communication to grass-root level 										
6. Impact on availability of high-quality anti-TB drugs	<ul style="list-style-type: none"> • Availability of drugs was already ensured before the Partnership. However, when the country started competitive bidding, delays occurred in procurement which prompted use of GDF (application submitted in Aug 2003) • MDR has been very low to date so no use of Green Light Committee • Good distribution system for availability up to HC level 										
8. Other Issues	<ul style="list-style-type: none"> • Stop TB Partnership is not conceived as a separate entity from WHO's regular funded activity by all stakeholders including WHO country and regional office • Fear of some major individual partners going alone • No contingency plan between the cycles of different funding agency projects • Concern shown even at the highest levels about creating separate entity just labelling Stop TB. Suggestion to incorporate these initiative through existing facilities and organisation • Concern shown for creating separate structure and projects through establishment of HIV/TB working groups and action plan. 										

EVALUATION OF STOP TB PARTNERSHIP: SOUTH AFRICA	
TORs	FINDINGS / EVIDENCE
1. Background	<p>Basic data</p> <ul style="list-style-type: none"> • 45 million people in 2003, 50% urbanised, Pop growth: 0.01%. • 40% Unemployment, Gini coefficient among highest in world • High burden of disease: especially due to poverty and affluence, trauma and AIDS. • Key indicators: TFR: 2.5%; IMR; 58; U5M: 75; Life expectancy: 45 years • Estimated 5 million PLW HIV/AIDS. Antenatal clinic HIV Prevalence 2002: 26%. • 9 Provinces, with fair amount of autonomy within national framework. • National Dept of Health develops legislation and policy, advises on budget allocation based on provincial populations and monitors progress. Provincial governments are responsible for implementation of policy and decentralisation of services to districts • 54 Local Government Health Districts - devolution of responsibilities and budgets still under discussion. • 800 hospitals (both private and public), 3,300 provincial and local government Community Health Centres and Clinics and approximately 1,000 mobile clinics. • Approx 5,000 beds specifically for TB patients. Patients admitted for a variety of periods, mostly for severe disease linked to AIDS, Multi Drug Resistance and chronic disease. Most clinics have staff supervising the treatment of TB patients. Very few TB patients are treated outside the public health system. • No charge for TB diagnosis or treatment in the public sector. <p>TB estimates</p> <ul style="list-style-type: none"> • A total of 224,020 TB patients were treated in 2001. • New smear positive rates: 2001: 202/ 100 000 (83 000 cases); 2002: 229/ 100 000 (98 800 cases) due mostly to the AIDS epidemic. 60% with dual infection. • DOTS coverage 2001: 77%; case detection in DOTS areas 72%; success rate: 66% <p>Main TB partners</p> <ul style="list-style-type: none"> • External: Belgium Development Aid, CDC, DFID, IUATLD, KNCV, Massive Effort, Medical Research Council, various University Departments, USAID and WHO • NGOs: SANTA, Life care, TB Care, TADSA, CHOICE, Operation Hunger & Soul City <p>NTP priorities</p> <ul style="list-style-type: none"> • Aim of Medium Term Strategic Plan is to increase DOTS coverage to 100% by 2003, treatment success to 85%, interruption rate to less than 5% and to increase the case detection rate to 70% by 2005. • Expand use of the electronic TB Register, improve data quality and use of quarterly reports at facility, district, provincial & national level to strengthen management of the TB programme at all levels. • Ensure a skilled TB person in each province in advocacy and communications. • Build provincial partnerships and personal communication at district level • Expand Community Based DOTS programme • Build better HIV/TB partnerships at National and Provincial level, also with prisons • Involve private practitioners and private sector (media, mines, Eskom etc.) <p>Chronology</p> <p>1996 – Review of National TBCP with WHO / IUATLD support. DG support for DOTS strategy as national policy, expanded national TB unit, training workshops, strong support for advocacy, first annual TB Report and wide coverage of World TB day</p> <p>1998 – World TB Day. GTB listing of South Africa as a country where progress is slow, resulted in greater political awareness of the country's response</p> <p>2000 – Minister of Health and Minister of Finance attend the Amsterdam STBP meeting</p> <p>2001 – Medium Term Strategic Plan developed at meeting with all partners. National TB Team upgraded to a Directorate and becomes part of the AIDS and TB Cluster.</p> <p>2002 – Externally assisted (WHO, KNCV, IUATLD, DFID, CDC) review of TB programme. Provincial plans developed and agreed to by Heads of Provincial health depts</p> <p>2003 – World TB Day: National TB Advocacy Plan for 2003 – 2005 launched</p>

<p>2. Key trends in TB control / DOTS strategy</p>	<ul style="list-style-type: none"> • Medium Term Strategic Plan accepted and published as a National Department of Health Document • Staff trained in DOTS areas to district level. Commitment to more rational rotation of TB trained staff. • DOTS Programme now the official policy and implemented to varying extent in all districts at health centre level, most hospitals not yet included • DOTS policy: recording & reporting system accepted by key partners: Mines+Prisons
<p>3. Impact of the Stop TB Partnership on political commitment to Stop TB</p>	<ul style="list-style-type: none"> • Since the Amsterdam Meeting in 2000, the Minister of Health has been very actively involved and supportive. • Since 2000 the national TB programme team has been upgraded into a Directorate and expanded to over 20 people. Provincial TB coordinators have been appointed in all provinces. • The Partnership is reported to have increased willingness on the part of Health Departments in the SADC Region to cooperate with projects (eg Monitoring and evaluation, Surveillance for MDR TB, and Lab QA & QC). • The Stop TB Initiative is no longer seen as a WHO Project at national level, although StopTB is linked in the minds of many in the country to World TB Day.
<p>4. Impact on partnership building</p>	<ul style="list-style-type: none"> • Interviewees said that national and international support for TB has increased in the past 3 years, and there has been a marked increase in donor funding • Respondents said that the StopTB Partnership seems to have encouraged donors and international technical agencies to work together in promoting the DOTS strategy • There is no formal partners forum in South Africa (possibly because all funds needed to run the TB control programme come from the government budget), however NGOs and other partners have been involved in developing the TB Control Plans at national and provincial level, in the ad hoc and routine meetings on TB control at national and provincial level and in annual programme reviews and capacity building programmes. • Partners have also been involved in supporting local NGOs in organizational development and training activities. • Partnership as a way to solve complex problems tends only to happen ad hoc. • Evidence of the StopTB Partnership adding value in South Africa since 1998 / 2000 is the international TA supported by different donors including a WHO Medical Officer, and a DFID consultant, and CDC monitoring and evaluation expert since 1998 • Links with HIV/AIDS Programmes and other Government Departments such as Education and Correctional Services need to be strengthened • The attention on the TB programme creates some tensions within the DOH.
<p>5. Impact on TB awareness</p>	<ul style="list-style-type: none"> • Wide awareness of World TB day – lots of activities undertaken, events involving politicians and well known personalities on radio, TV etc. Advocacy materials developed, including an Annual Report. The impact of World TB day, especially in relation to the effort which goes into it is being questioned. Extending communications and advocacy activities throughout the year is being pursued by the national Advocacy & Communications Officer, with support from the Massive Effort. • Cricket World Cup linked to World TB day in 2003 with 6 countries with high TB burdens participating and a series of StopTB videos involving cricket stars reaching over 300 viewers. • Some awareness of the Stop TB website by those involved in the TB programme.
<p>6. Impact on funding for TB</p>	<ul style="list-style-type: none"> • The funding for TB Control comes from the general government health budget in terms of staff, facilities, laboratory test, drugs etc. The budget for the National TB CP team was R5 million (\$700 000) in 2002 and increase of about 40% from 2001. • Estimated that IUATLD and KNCV together with USAID, DFID and contributed about R2.5m on technical assistance and R2m for MDR TB surveillance in 2002. • The Belgium Agency for Development has just approved R28m (\$3m) for the expansion of the HIV/TB programme at provincial and district level, and GFATM has approved \$8m for HIV/TB including counselling, treatment, training and research. • Aventis has put €15m into the Mandela Foundation for TB Community Health Workers. These funds were seen as important to facilitate some of the changes needed to strengthen TB control at provincial and district level but there were complex constraints to utilizing them effectively in the short term. These constraints are linked closely to District development and the Cabinet's recent decision to introduce ARVs, both of which are key current general health issues in South Africa.

	<ul style="list-style-type: none"> • It should be noted that Partner funding comes with a significant time cost to the national TB team.
7. Impact on availability of high-quality anti-TB drugs	<ul style="list-style-type: none"> • The Government has always gone out to tender for TB drugs (using WHO regimens). • South Africa was among the first countries to adopt fixed combination TB drugs • No use made of the GDF to date, however there may be worth exploring procurement via the GDF if the suppliers were to register their products in South Africa via the Medicines Control Council. This would mean having a legal presence in the country.
8. Suggested roles for Stop TB Partnership	<ul style="list-style-type: none"> • The StopTB Partnership should be more visible as brand. Starting with joint logos on Partner documents. • Help promote the concept of partnership down to field level by using the partners at national level to help solve specific problems in the field. • Encourage the field staff to look for local partners to solve problems and become part of the Global STOP TB Partnership not just on World TB Day. • Strengthening technical communications capacity. • Strengthen capacity of NGO and health service staff to work more effectively together. • Encourage the Provincial programmes to implement programme effectively • Encourage ownership and validation of TB Programme data at district and facility level • Capacity building to help write grant proposals • An ad hoc meeting to discuss how to streamline StopTB Partnership activities and how to extend partnerships to district and field level in South Africa would be a useful way to take the process forward.
9. Data issues	<ul style="list-style-type: none"> • Compatibility of the recording and reporting system with the National Health Information system is being worked on but remains a problem • The initiation of the electronic TB register has resulted in centralisation of TB reporting system. And in some areas the ownership of the TB Quarterly reports is also a problem. The statement is made too often "The quarterly reports are something required by our supervisors!" • Concern was expressed about validation of TB data in some areas
10. Other Issues	<ul style="list-style-type: none"> • Coordination and cooperation with the HIV/AIDS programme is not optimal. This is especially critical in the light of the Governments stated intention to introduce ARVs • The implementation of effective TB control in many districts is difficult despite high level consensus. • Interaction even with the limited number of partners can be time consuming and detract from capacity to support and problem solve in the field. • Poverty and TB needs to be a more central issue.

EVALUATION OF STOP TB PARTNERSHIP: INDONESIA	
TORs	FINDINGS / EVIDENCE
1. Background	<p>Basic data</p> <ul style="list-style-type: none"> • 17,000 islands, 30 provinces, 357 districts, 4,069 sub-districts, 64,367 villages • 217 million population, 60% population in Java (7% of land mass) • 3 types of health institutions – 7,200 health centres, 1,100 hospitals, 34 lung clinics • 3 different systems within the Ministry of Health have responsibility for TB services – DG community health, DG medical/hospital services, DG communicable diseases • 3 sources of funds – national (APBN), provincial (APBD1) and district (APBD2) • Decentralisation initiated in 2001 - Districts now have implementation responsibility • Some health centres charge for TB diagnosis, however once a patient has been proved positive, TB drugs and services are free. Some districts charge for other services for TB patients, however some districts give these free. <p>TB estimates</p> <ul style="list-style-type: none"> • CDR 29% in 2002. Targets under the 5 Year Plan are: CDR of 40% by 2002, 50% by 2003, 60% by 2004, 70% by 2005 • Estimated incidence of smear positive cases is 122 per 100,000 in 2002 <p>Stated NTP priorities</p> <ul style="list-style-type: none"> • 20% of health centres trained – want to increase to 60% in 2003. Also want to expand DOTS programme to lung clinics, train doctors, nurses, laboratory personnel etc. • Beginning to target district hospitals, but difficult as case holding is weak in hospital settings. • Next year, aim is to increase advocacy and communication in the villages. • Advocacy at provincial level to ensure enough / increasing funds are allocated to TB • Aim is to develop links with prisons/ MoD/ hospitals/ academia etc (Public Public Mix), as well as with the private sector <p>Main TB partners</p> <ul style="list-style-type: none"> • External: WHO, KNCV, NLR, USAID (\$2.5 million a year), CIDA (\$0.9 million a year), GFATM (6.2 million, 2 years) • NGOs: World Vision, Islamic RBO, Catholic RBO, Coalition for Healthy Indonesia, PPTI: Indonesian body similar to IUALTD, PKK: Women Welfare Movement <p>WHO TB team</p> <ul style="list-style-type: none"> • 1 International Medical Officer (joined June 2002) • 1 National Programme Officer and 3 National Consultants (2 in the field) <p>Chronology</p> <p>1995 – KNCV started first DOTS projects in 10 health centres, expanded this in 1999</p> <p>1999 – SERO meeting attended by Minister of Health – first time became aware of seriousness of problem</p> <p>1999 – Minister of Health and Minister of National Planning Board attended Amsterdam STP Meeting</p> <p>1999 – World TB Day – Minister of Health announced launch of Gerdunas TB movement</p> <p>2000 – Guideline / manual for TB control and management revised</p> <p>2000 – Decree by Minister of Health for all TB drugs to be free of charge</p> <p>2000 – KNCV started Hospital DOTS Linkage project (pilot in Jogjakarta)</p> <p>2001 – 5 Year Strategic Plan developed</p> <p>2001 – First meeting of TB Partners Forum</p> <p>2002 – DOTS Programme accelerated, including project to extend DOTS programme into hospitals (Hospital DOTS Linkage Project)</p>
2. Key Trends in TB control / DOTS strategy	<ul style="list-style-type: none"> • Moderate progress made in case detection and treatment success rates - CDR increased from 12% in 1999 to 29% in 2002, and cure rate up from 57% to 86% • Currently 40% of health centre staff are trained in DOTS. DOTS implemented at health centre level, but hospitals not yet included – pilot study now in operation

<p>3. Impact of the Stop TB Partnership on political commitment to Stop TB</p>	<ul style="list-style-type: none"> • Increased political commitment to TB generated and sustained through attendance by senior officials at high level meetings – Minister of Health created Gerdunas TB after the Amsterdam Declaration, and issued the decree that TB drugs should be free for the population, pushed for the 5 year Strategic Plan etc. after attending other international meetings organised through the Global Stop TB Partnership, including Cairo, Paris, Okinawa (President also went), New York, Washington, Montreal etc. • Global Stop TB Partnership has given the NTP programme a vision, mission and direction, and put TB in an enviable position compared to malaria, HIV/AIDS etc. w.r.t. awareness and political commitment, even though not many people outside the central NTP Programme can distinguish between WHO Stop TB and Stop TB Partnership. • 5 year Strategic Plan – requested by WHO / Stop TB Partnership, and developed as part of the GDF application (which asked for letters of support from the government and partners). A number of technical agencies also signed the GDF agreement itself. • Before the plan was written in 2001, different projects were run in different places on a patchwork basis. The plan started being implemented in late 2002 / 2003. It was largely developed by WHO with KNCV involvement, but is now owned more by NTP Programme. However, some bits are missing – i.e. hospital project being undertaken by Gorgas / KNCV, and there is no joint government / partners implementation plan in place as yet. Partners think that TB Partners Forum should be the forum for this.
<p>4. Impact on partnership building</p>	<p>TB Partnership mechanisms</p> <ul style="list-style-type: none"> • GERDUNAS - Indonesian Stop TB Initiative. This was set up in 1999 as a result of the previous Minister of Health attending the Amsterdam Stop TB Partnership meeting – originally it had 110 advisors and no lead / management, however the development of 5 year plan and change in Minister who is more committed to TB helped to change this, and now it is much more effective, with a core group etc. NTP Manager is the executive secretary, there are two advisory groups, and 6 ad hoc working groups (including TB HIV, M&E, Logistics, Social mobilisation, Training and Research). The government funds most of the Gerdunas activities, but some activities are covered by KNCV, WHO and GFATM monies. KOMNAS is the decision making forum, headed by the Secretary General of Ministry of Health, and including top people from other ministries, including the DG finance, as well as leaders of some NGOs, RBOs etc. KOMLI is the technical expert group, headed by a leading pulmonologist with academics, public health physicians, pharmacists etc. Donors are not included. • TB Partners Forum / Indonesia Partnership Forum. Chaired by Director DTDC, meets every 3-6 months (partners would like more often; government don't feel the need for it to be more often). First meeting March 2001, not clear if this was a result of Global Stop TB Partnership or not. Mostly international partners, issues discussed go to the Gerdunas Working Groups and Komli. Request by partners for more information about government programme (budgets etc.) not responded to as yet. • Stop TB External Monitoring Mission (Feb 2003) included Global Stop TB Partnership Coordinating Board Members, Director KNCV, Mario Ravliogini, Irene Koek, USAID, MSH, WHO HQ, WHO Regional Office, WHO Indonesia etc, and therefore encouraged partnership in country. <p>Other partnership mechanisms</p> <ul style="list-style-type: none"> • Within government. Better coordination between community health, medical/hospital services and communicable diseases recommended by 2003 External Monitoring Mission, however only evidence of links so far are lung clinics beginning to submit data, training staff etc. Links started in 2003 between MoH and other sectors • Consultative Group for Indonesia. Major partners involved. Called for Working Group on Health, however only recently set up. WHO acts as secretariat, and there is a rotating chair. This group arose out of 'Partners in Health' donor-only meetings, which became quarterly meetings with MoH, including Minister of Health etc. • GFATM Country Coordinating Mechanism. Set up in 2002 by DG (part of GFATM proposal). Seen as an imposed mechanism by some, and potentially duplicating other mechanisms. However, government see it as relating to GFATM only, not overall. <ul style="list-style-type: none"> • TB was part of first round GFATM proposal (\$70.7 million over 5 years). Grant agreement signed in Jan 2003 for \$6.2 million over 2 years. Funds received to date: \$750,000 in April 2003 (Q1), \$750,000 in July (Q2)

	<ul style="list-style-type: none"> • GFATM TB application based on filling gaps identified in the strategic plan. • First round applications made for Malaria and HIV/AIDS (\$44 and \$16 million). Agreements signed June 2003, for \$8.3 million and \$6.9 million, but no funds yet • Tax free status for GFATM imports has not yet been agreed by MoH with MoF.
5. Impact on TB awareness	<ul style="list-style-type: none"> • NTP Manager is a member of the DOTS Expansion Working Group, GDF Technical Review Committee, involved in STAG meetings and GFATM TRP. This has raised awareness of TB and the Global Stop TB Partnership in particular, and encouraged her to push the message / brand to others. Awareness also promoted by attending meetings in Montreal/The Hague/Cape Town with Director DTDC and others. • Different partners now wanting to get involved (GFATM, ADB, JICA, NGOs - World Vision, TBC-TA). This is seen to be largely due to increased political commitment within the country (generated by Global Stop TB Partnership), and realisation outside the country that TB linked to poverty (also due to Global STP?). Also linked to the development of the 5 year Strategic Plan and the existence of the TB Partners Forum. • Wide awareness of World TB day – lots of activities undertaken, with advocacy materials developed, Gerdunas newsletters published, meetings in health centres with politicians, radio, TV messages etc. Some awareness about Stop TB website.
6. Impact on funding for TB	<ul style="list-style-type: none"> • Central TB programme: 2001: 20 bill rupiah - 2002: 35 bill rupiah - 2003: 50 bill rupiah. • Total funding from central govt to TB programme up from 90 million rupiah in 2001 to 1 billion in 2003 (includes funds for drugs purchased centrally and distributed locally). • However, due to decentralisation, and lack of accounts at lower levels, no specific data on provincial / district. In 2001, Minister called on all provincial health governors to allocate 15% of their health budget to TB, however not all provinces are doing this. • TB staff in the districts are employed (and therefore funded) locally.
7. Impact on availability of high-quality anti-TB drugs	<ul style="list-style-type: none"> • Indonesia applied for GDF support, due to a lack of funds for drugs (WHO facilitated the application). They have just started to get funds, and there are now reported to be sufficient drugs, with the drugs to be distributed to patients shortly. However some problems have been encountered, with the release of the first consignment of 'in-kind' GDF drugs from customs, and with negotiating tax-free status for GDF drugs procured with GFATM funds (as these are not 'in-kind'). This second consignment has not yet been approved as the MoF has not yet agreed to import them tax-free to the MoH. • An option may be to route the drugs through WHO for MoH, but this is not ideal. The NTP Manager would prefer GFATM funds to go directly to the GDF procurement agent and not go via the country in order to try and reduce the delay in receiving the drugs. • GDF support was also sought due to concerns about the quality of locally produced drugs, and to introduce 4FDCs. Local manufacturers have now applied to get on the GDF white list and held discussions to introduce 4FDCs and potentially reduce prices.

8. Suggested roles for Stop TB Partnership	<ul style="list-style-type: none"> • To provide TA to raising awareness in communities. • Supporting technical exchange between partners, and to supporting partnership working in country (i.e. fund secretariat, provide TA etc.) • There is a need for global level operations of Stop TB Partnership – Working Groups and Task Forces – however need to have recommendations translated into county level actions, in particular for the advocacy and communication activities.
9. Data issues	<ul style="list-style-type: none"> • Accuracy of surveillance data is seen as a real weakness. In 1999, 40% of cases were not evaluated, leading to a low success rate, 50%. • Partnerships⁹ have had an impact on trying to improve the accuracy of surveillance data at country level – WHO taken the lead on this, however data is from health centres only – data from hospitals, private sector, prisons and MoD are not included. • Data from lung clinics included for the first time in 2002 data collection
10. Other issues	<ul style="list-style-type: none"> • WHO Medical Officer post vacant for 18 months, and current NTP Manager appointed in April 2002, so pace improved in the last year but still need to strengthen partnership working – particularly between partners (donors and implementers) and government. • Provincial Gerdunas are in place, but not working – Feb 2003 mission suggested to revitalise them. Some feel that these could be an effective way of selling the 5 Year Strategic Plan to provinces (not consulted on the plan itself), however, others feel that local DOTS committees should be established instead. Capacity building required. • PRSP – Interim PRSP in place, 4 working groups – need to engage with this more. • HIV/AIDS a relatively small problem compared to TB, however TB is now the biggest OI in HIV/AIDS. Appear to be few links between the HIV/AIDS and TB programmes. • Some partners not included – in TB Partners Forum, or in Gerdunas, and not aware of what others are doing (i.e. ICDC funded by ADB has 30% of \$51 million to support training in DOTS, equipment and NGOs in 7 provinces. But only working with the NTP Manager at central level, although some coordination at district and provincial levels.

⁹ GDF application and monitoring process should improve data collection through requests for WHO annual reports, quarterly reports, drug stock and quality control information, budgetary and expenditure information. This was not mentioned specifically by respondents.

EVALUATION OF STOP TB PARTNERSHIP: BRAZIL	
TORs	FINDINGS / EVIDENCE
1. Background	<p>Basic data</p> <ul style="list-style-type: none"> • 172 million population • 10 health regions, 27 states, 5,562 municipalities • Approx 6,500 hospitals, 65,000 health centres, 17,000 Health in the Family teams • National Reference Laboratory, 10 Regional labs, 27 State labs, 3,994 Municipal labs • End of military era in 1985 led to a new constitution in 1988 and the Health Law (Lei Orgânica de Saúde) of 1990 which universalised access to medical care, unified the public health system supported by the Ministry of Health and the National Institute for Medical Assistance and Social Security (Instituto Nacional de Assistência Médica da Previdência Social--INAMPS), and decentralized the management and organization of health services from the federal to the state and, especially, municipal level. • TB Programme under the SVS (Secretaria de Vigilancia em Saude) since June 2003 <p>TB estimates</p> <ul style="list-style-type: none"> • WHO estimated 118,000 new cases in 2002 - government recorded 93,000 new cases • HIV prevalence 0.5%. Approximately 7% of all TB cases are HIV+ (MoH estimates from 1999 – 2001), and based on survey data, 1.1% of cases are MDR TB (45% of these in Rio de Janeiro) • 236 municipalities in Brazil have 75% of the TB cases, mostly in the State capitals. • 2001 data shows 11% of new smear positive cases were lost to treatment, 10% were transferred (and so the final patient outcome is not recorded) and a 6% mortality rate. 21% of the re-treatments were lost to treatment, 12% were transferred, and 10% died. <p>Programme funding</p> <ul style="list-style-type: none"> • 3 sources of government funds for TB – from national, state and municipal levels. 75% of the TB Programme is funded by the federal government directly & through transfers • Transfers from Federal Government to State and Municipalities for TB include PAB – per capita payment to municipalities for basic health services (includes TB); TFECF – fund for control of epidemiological diseases (includes surveillance activities etc); and other payments, including payments for REMEDIOS, VACINAS, INSECTIDAS, LABS • Federal government buy TB drugs and distribute to States who supply Municipalities <p>Stated TB priorities</p> <ul style="list-style-type: none"> • To increase by half the number of health centres using the DOTS system in municipalities with higher TB rates – these municipalities to receive increased funding. • To build capacity, decentralise further and increase supervised treatment of patients • To improve case finding through strengthening the Health in the Family programme <p>Main TB partners</p> <ul style="list-style-type: none"> • External: PAHO/WHO, USAID – have also funded projects by MSH and John Hopkins • NGOs: Damien Foundation, AIFO (Italian), Bemfam (Brazilian) and DAHW (German)
2. Key Trends in TB control / DOTS strategy	<p>Trends in TB</p> <ul style="list-style-type: none"> • Number of new cases remain fairly constant at approx 80,000 from 1990-2000 (2001 & 2002 data incomplete), with the number of smear positive new cases approx 40,000. • Mortality per 100,000 population has also remained fairly constant at 3.5 -4 since 1985 • In 2000, 48.4 new cases were recorded per 100,000 population, down from just under 60 in 1995. However, the rate of smear positive cases has remained constant at just under 30. Highest incidence of TB in the Rio de Janeiro and Amazon states. <p>Trends in DOTS</p> <ul style="list-style-type: none"> • DOTS coverage reported by the MoH to be 13.3% in 2001, 17.4% in 2002 and 23.1% in 2003 (2003 figure is quoted as an estimate) • Brazil formally adopted the DOTS strategy in 1999, and it has now been incorporated into the TB manuals and National Strategy. However, it is reported that there is limited roll-out, with direct observation reported only at the National Reference Centre, and 1 health centre in Rio de Janeiro. • DOTS programme not operating in prisons. Ministry of Justice responsible for health care of inmates, but MoH report that links are beginning to be developed. National

	<p>Reference Centre (under MoH) is conducting a project to investigate TB in prisons</p> <ul style="list-style-type: none"> No links reported with the private sector, although TB is a notifiable disease so all cases should be recorded, and patients still have to collect TB drugs from the public sector clinics as there are no other outlets for TB drugs. Current weakness in the system seen to be direct supervision / observation of patients
<p>3. Awareness of Global Stop TB Partnership</p>	<ul style="list-style-type: none"> Despite a presentation by the TB Programme on the Amsterdam Declaration of 2000, the global goals for TB reduction and the structure of the Global Stop TB Partnership (including working groups, board, secretariat, GDF, Global Partners Forum etc.), there seemed to be little recognition of the STOP TB brand in Brazil and of the Partnership. No branding of recent National TBCP documents with STOPTB Logo. Understanding of the role of the Global Stop TB Partnership and its components (i.e. Coordinating Board, Working Groups, GDF etc.), and its interaction with other global initiatives (i.e. GLC, GFATM etc.) is not entirely clear to MoH or to some partners No awareness of Global Stop TB Partnership at State and Municipal levels and limited awareness of the Partnership at central levels. Although the DOTS strategy has now been accepted by the MoH, it is seen as an initiative presented by PAHO / WHO Partners feel the Stop TB Partnership has had some impact in technical terms, but not financial terms (due to size of MoH budget - 2nd largest budget – approx \$20 billion).
<p>4. Impact of the Stop TB Partnership on political commitment to Stop TB</p>	<ul style="list-style-type: none"> Involvement in international meetings, and international pressure have helped to raise the political commitment to TB, alongside national pressure to prioritise TB activities. TB is one of five stated priority areas including maternity, child care, leprosy and EPI The MDGs, and the international TB goals have been adopted into policies and plans. 5 year National Plan developed for TB by MoH with input from PAHO in 1998 (now under revision). TB manuals, guidelines also developed, based on DOTS strategy. At the biannual meeting of the Brazilian Medical Association (8,000 attendees) in 2003, the new Minister of Health announced he was “ashamed of Brazil’s record in TB and leprosy and for which there was no excuse!” – this was seen to be due to international/national pressure/rankings etc. New government, success of pilot projects and continued technical discussions with PAHO / WHO are reported to have convinced the Brazilian government to incorporate DOTS into the TB programme, and integrate with family medicine programmes, such as the ‘Health in the Family’ initiative. There are 17,000 teams at present, with a doctor, a nurse and five community agents to visit / supervise 800-1,000 families. Adoption of DOTS strategy by MoH reported to be due to facilitation by PAHO (who were supported by Stop TB with evidence from other countries, access to training, TA etc.), but not necessarily on the direct involvement of the Stop TB Partnership itself. PAHO have helped with developing plans, training, supervision, annual evaluations of the programme and in organising regional meetings of TB teams from other countries. Holding a Global Stop TB Partnership Coordinating Board meeting in Brasilia in April 2003 was not thought by those we spoke to to have an impact on the decision of the Brazilian MoH to adopt the DOTS programme. However discussion with other Ministers of Health at the meeting may have made more of an impression.

<p>5. Impact on partnership building</p>	<ul style="list-style-type: none"> • Stop TB Partnership (and involvement of other partners in Brazil) has resulted in a change in mind-set in Brazil, and a new vocabulary – donors, stakeholders, partners etc. Realisation now that partnership working is important, even if MoH is still the major financier of TB. • MoH is encouraging partnership working, where it reinforces the local programme and helps sustainability – coordination and achieving consensus on technical issues is key as is avoiding competition between partners / MoH – partners need to be under MoH • Sustainability and ownership are seen as key priorities by all partners (MoH & others). • Ministry of Health currently undertaking ‘stock-taking’ exercise with NGOs and other partners to identify who is doing what where. No formal mechanism as such, however many TB partners (i.e. USAID and PAHO) are involved in technical meetings on TB. • MoH sees NGOs as having a role in advocacy and prevention, not direct provision – MoH partners with NGOs and municipal secretariats to cover indigenous population • AIDS programme is seen to be working better than TB programme in Brazil – aim is now to develop links between the TB and Leprosy programmes. The latter have traditionally been more closely aligned. <p>Partnership mechanisms:</p> <ul style="list-style-type: none"> • Technical committee for TB Programme, including scientists, external consultants etc. • State and municipal level coordination mechanisms – not TB specific, but discuss TB • There is a national meeting in Nov with TB and Leprosy NGOs to which AIDS NGOs have been invited in an attempt to coordinate with NGOs informally at this stage. • Bilateral meetings with donors occur to discuss funding sections of the National Plan
<p>6. Impact on TB awareness</p>	<ul style="list-style-type: none"> • Public awareness of TB is very low – and there is still considerable stigma around TB, TB is seen as a disease of the past, and of the marginalised groups. However, there are plans to raise public awareness through joint TB / leprosy campaigns (despite the expense of national Radio and TV programmes) • The Health Promotion material produced by and the Website of the MoH was said to be excellent. • Campaigns have been held for World TB Day, as well as on the Brazilian TB day, 17 November. However, there is an issue of country-ownership, with replacing the Brazil day by the World TB day, that not all respondents were happy with – diluting message. • Awareness of TB and DOTS among general health professionals also reported to be a problem – There is an effort by the Damien Foundation to develop TB curricula at Medical and Nursing Schools. • Meeting at Federal level in July 2003 for TB Coordinators of States and State Capitals had DOTS strategy as most important message at meeting, so awareness is now increasing, but there is still a need to get this down to smaller municipalities • Apart from World TB Day (replacing the Brazilian day) it does not appear that the Stop TB Partnership has had an effect on awareness of TB in Brazil – among professionals or the public
<p>7. Impact on funding for TB</p>	<ul style="list-style-type: none"> • It is not clear from the data whether there have been any changes in the funding for TB in Brazil over recent years, due to the difficulties in identifying allocations for TB and expenditure at the different levels: Federal / State / Municipalities, however there is a move towards earmarked funds for TB in transfers from federal to municipalities • A system exists, whereby municipalities get bonus payments for treating / curing TB patients. This has been in operation since 1993 (bonus for curing TB), but has altered recently, in that the payment is now made if patients are cured with DOTS. There used to be no guarantee that these funds went to TB, but recently changed. • Other initiatives include linking with the ‘Zero Hunger’ programme, whereby patients receive food parcels for 6 months after they have been cured, travel payments etc. • No GFATM proposal was submitted for TB, although there are ones for malaria and AIDS. This is because there was felt to be no need for additional funds for TB in Brazil
<p>8. Impact on availability of high-quality anti-TB drugs</p>	<ul style="list-style-type: none"> • Brazil has not applied for GDF support, as they produce sufficient TB drugs locally – the Government invests 1.2 bill Reais in drug manufacture a year - 16 mill on TB drugs • It was reported that although Brazil has produced TB drugs (among others) for some time, the decision to produce TB drugs in Brazil has now been enshrined in policy. • ‘Centre for Medications’ supplied all drugs centrally for several diseases including TB until 1996 when the centre was closed. In 1998, the ‘National Policy for Medications’ was developed, which included a directive for the Federal government to procure and

	<p>manufacture drugs, and outlined responsibilities at different levels of government.</p> <ul style="list-style-type: none"> • Essential drugs list developed in 2001 (revised 2002), which includes TB drugs, and there is a General Policy of Conduct, with 8 directives on safety, quality, control etc. • Safety and quality concerns reported in relation to quality of raw materials imported – in early 2003, production of some TB drugs halted due to poor quality imports. • ARVs have been manufactured and supplied without charge since 1996. • Main problems were are logistics / distribution of drugs to inaccessible areas
<p>9. Suggested roles for Stop TB Partnership</p>	<ul style="list-style-type: none"> • Brazil is keen to participate in and learn from the international community • To create a positive political environment to influence policy • To provide technical assistance to TB programme – and capacity building • To help acceleration of DOTS in country – enable learning from other countries • To provide funding for communication about TB on Radio & TV (very costly in Brazil). • Request that STBP provide documents, training materials, public information materials and the Stop TB website in Portuguese to encourage the rapid uptake of new evidence and a two-way debate and joint learning. • The biennial ABRASCO (Public Health Association) was seen to be an important forum with over 8 000 people attending from all over the country. • Ensure that there is good coordination of partner projects with the MoH
<p>10. Data concerns</p>	<ul style="list-style-type: none"> • Concerns about discrepancy between 2002 WHO estimate and government figures • Computerised information system adopted in 1995 but was converted from DOS to Windows in 1999, which resulted in loss of data. Before 1995, data was collected manually (some feel this was more accurate), but not collated at a national level • Concerns that often what is recorded in the books does not make it onto computer. • All states have own data recording system –it has been difficult to get them to use the same one – problems of getting centralised information in a decentralised system • Incomplete picture due to lack of data on transfers in the computerised system • Concern was expressed that the Brazilian computerised system SINA also produces artificially high success rates • Very little analysis or use of reported data at health facility level to improve data quality or outcomes • MoH hoping to improve flow of information, and speed of reporting (currently working with 2001 data), by putting computer information system on-line for local reporting • Validation exercise undertaken by CDC / USAID in 2002 found 70% of cases detected recorded in the computer information system, but only 50% of outcomes are recorded
<p>11. Other issues</p>	<ul style="list-style-type: none"> • 5 different heads of the TB programme since 1998. New government was installed in early 2003, so there have been some recent changes in MoH personnel. • There was no problem with availability of drugs, laboratories or human resources, but interviewees see the central challenge facing the TB programme (and health service in general) is to improve the planning, evaluation and management capacity at all levels, build the technical know how in health professionals and strengthen the decentralised health networks especially through the Health in the Family Programme. • Only 50% of Municipal labs perform microscopy services, due to way labs are funded, lack of interest from doctors and nurses, poor equipment and inadequate supervision • Regular rotation of staff was also reported as a problem • Information task a long time to penetrate to many peripheral areas

EVALUATION OF STOP TB PARTNERSHIP: AFGHANISTAN	
TORs	FINDINGS / EVIDENCE
1. Background	<p>Basic facts</p> <ul style="list-style-type: none"> • Afghanistan is in a complex emergency situation and has been slowly emerging from over two decades of civil war and strife following the removal of the Taliban regime in late 2001. Security remains a key problem in many parts of the country and is showing little sign of improvement. A transitional Government is in place and elections are expected in mid 2004. • There are 8 Regions (these are not officially recognised demarcations but have traditionally been used by UN organisations for operational purposes), 32 Provinces 381 districts. Total population is estimated at 25.47 m. • The DOTS strategy was officially endorsed by Government in 1997. Coverage has increased from 11% of the population in 1998 to 39% in 2002 but at the end of August 2003 only 79 districts out of 387 had one or more facilities providing DOTS. • Treatment success rate in 2000 was estimated at 86%. The incidence rate is estimated at 314 new cases per 100,000. The Smear positive pulmonary TB incidence rate is estimated at 141 per 100,000 (1999). New cases identified in 2001 and 2002 were 9668 and 13,794 respectively (+30%) with an estimated case detection rate of 20% in 2002. Notification rates have tripled from 15 per 100,000 in 1998 to 44 in 2001 • TB problem has been exacerbated by the repatriation of approx 1.5 million refugees from Pakistan since the beginning of 2002, with perhaps 2 million more to follow. • There is major inequality in TB provision reflecting regional disparity in health services as a whole. 38% of all facilities claim to be involved in some TB control activity. However, only 19% had TB laboratory supplies, and only 10% have a microscopist. While 13% claim to offer short-course treatment, only 10% had TB outreach workers (is it a remarkable difference?). Only 6% engage in case finding (it is internationally accepted that case finding be passive), offer short-course treatment, and have TB registers, outreach workers, a microscopist, and TB laboratory supplies available. 63% of the provincial hospitals claim to be involved in TB control activities, but only 39% offered all activities and have necessary laboratory and staff. Source: Afghanistan National Health Resources Assessment December 2002 (There several reserves about that report but I understand it is the only source of information) • Women are disproportionately affected by TB. They account for 2/3 of smear-positive patients in 2001. Operational research is ongoing to understand the reasons why. • There is heavy reliance on external inputs in both the financing and delivery of services. It is estimated that donors account for around 90% of total recurrent health spending and that 70-80% of free health services are delivered by local or international NGOs. • A Health Policy and Strategic Plan for TB were developed in 2002 and have been used as a basis for planning TB activities since. The strategy is currently being finalised before seeking Ministerial approval. It aims to achieve 30% DOTS coverage by the end of 2002 and achieve the global targets by 2005 at a cost of some \$12m. • MoH is planning to decentralise the planning and implementation of health services to the 32 provinces. With support from the World Bank and others, Government is planning to contract with NGOs to deliver the essential package for districts (the so called PPA approach) <p>Key partners</p> <ul style="list-style-type: none"> • The main TB partner is WHO providing overall technical and financial support, with 2 technical advisers at central level and support to 16 Regional coordinators. It has often fulfilled a gap filling function due to weakness within the NTP. Other key partners include CIDA, JICA, Italy, MEDAIR, GMS, other NGOs and Norway. WFP provides energy basket to TB patients. JICA has plans for a 5-year programme on TB control. • A GFATM proposal was approved during the 2nd Round. The \$3.13m programme focuses on capacity building. The grant agreement has yet to be signed. A proposal has been submitted for the current round. This proposal requests \$19.5 m. Nearly half of this (\$9.2m) is for TB, of which some \$5.1m is for drugs

	<p>Stated NTP Priorities</p> <ul style="list-style-type: none"> • Regular and adequate supply of anti-TB medicines to all levels of NTP; • Availability of laboratories for diagnosis, reference and training purposes • Training of staff on DOTS at all levels • A strong and reliable logistic system • Recording and reporting • Health education • Food distribution to TB patients as a way of encouraging attendance • Advocacy initiatives aimed at sustaining DOTS' momentum and funding • Coordination between different programme's stakeholders • Supervision on DOTS activities at all levels • Operational research on key aspects of DOTS implementation • Incentives for national key staff <p>Chronology</p> <p>Afghanistan has had a National Tuberculosis Institute (NTI) since the 1970s 1992-97: TB programme effectively dormant due to insecurity 1997: DOTS approach approved and introduced in Kabul 1999: Original TB Guidelines approved April 2002: Arrival of "Stop TB" Medical Officer posted to Kabul April 2002: National Coordination Meeting (Kabul,) reiterated the choice of DOTS as the strategy adopted by MOH to control TB countrywide. May 2002: National TB Officer appointed, for NTP July 2002: National Workshop On Communicable Diseases Control In Afghanistan August 2002: Development of Strategic Plan August 2002: Establishment of NIACC August 2002: First field trip of NTP manager to North and North-East regions to promote exchange of views and knowledge between TB workers in the regions and in Kabul. September 2002: Proposal submitted to GFATM October 2002: WHO Technical Officer for Administration and Logistics arrived in Kabul December 2002: National Workshop on Operational Planning at Regional and Provincial levels; second international Stop TB Medical officer posted in Mazar e Sharif Feb 2003: approval of GFATM proposal April 2003: process of developing TB guidelines began</p>
<p>2. Impact of the Stop TB Partnership on political commitment to Stop TB</p>	<ul style="list-style-type: none"> • A National Health policy was elaborated in 2002 and followed by an Interim Health Strategy for 2002 –2003 "A Strategy To Lay Foundations" in February 2003. It sets out 12 broad strategies of which 5 are considered top priorities. TB is not mentioned specifically but one of the priority strategies is to implement a basic package of essential services, and TB represents an important component of the package. • A collaborative approach has been taken to the development of a Strategic Plan to lead development of TB services from 2003 to 2005. It is currently being modified with assistance from WHO and Ministerial approval will be sought for it in the near future. • Nonetheless, TB often falls well down the list of priorities.. In many provinces security is the key issue. Within health, maternal health is a major concern in the north where maternal mortality rates are amongst the worst in the world.
<p>3. Impact on partnership building</p>	<ul style="list-style-type: none"> • Sector coordination is by the Consultative Group for Health and Nutrition (CGHN), formed in July 2002 for a transitional 18 months, with MOH, UNICEF, WHO and MSH. • TB is coordinated through an Inter Agency Coordinating Committee, convened in July 2002, meeting approx every three months. Members include key stakeholders (with the possible exception of the private sector). WHO and Medair act as the Secretariat. It is an advisory and coordinating body: a forum for debating TB control and DOTS expansion, to advise on managerial issues, to raise awareness among the public and the partners, to propose rational allocation of resources. The IACC tends to focus on issues such as development of the essential package and agreeing the guidelines. • Attendance by donors has often been poor. NGO appreciate the opportunity these arrangements offer for field staff to share lessons. The IACC has replaced monthly meetings between MoPH and largely Kabul-based NGOs. Funds have been provided by donors but focused on strategy and policy formulation rather than implementation. An increasing feeling that GFATM should meet the funding requirement for TB.

	<p>Key achievements of the partnership include:</p> <ul style="list-style-type: none"> development of revised TB guidelines. In the past NGOs provided services according to their own plans and guidelines and did not provide data to Government. A single set of guidelines have been developed which will soon be submitted for Ministry approval agreement on a Strategic Plan for TB. <p>A number of events have promoted regional lesson learning. TB levels in refugees and returning refugees is recognised as a key problem and a workshop is planned on this subject. A representative from Iran attended the first ICC meeting partly in recognition of these concerns. It has, however, proved extremely difficult for NTP staff to travel overseas and take advantage of learning opportunities (except within the EMRO region)</p> <ul style="list-style-type: none"> NTP manager: DOTS Expansion Course (Cairo, June 7-13, 2002); Regional Meeting of the National Managers of TB Programs in EMR (Damascus in September 2002). Deputy NTP manager: Inter-country Training Workshop on Research Methods for Tuberculosis and other Communicable Diseases (Cairo in October 2002). senior NTP staff attend STAG meetings. Two members will attend the KNCV anniversary meeting in the Hague in October WHO has signed tripartite agreements with a number of NGOs, NTP for TB control and the World Food Programme to formalise partnership arrangements.
4. Impact on TB awareness	Stop TB Day has had some success. Whilst it has been in place for a number of years, efforts have intensified recently reaching areas outside Kabul. WHO provided \$1,500 for each region to celebrate World TB day. Commemorative stamps were produced
5. Impact on availability of high-quality anti-TB drugs	WHO has recently procured TB drugs through IDA. A submission is now being prepared to go to the GDF to cover the cost of first line drugs. This follows a meeting between NTP programme manager and GDF at EMRO. GDF materials have been circulated to key partners. No requests have been made to the Green Light Committee as Afghanistan does not have the infrastructure to utilise second line drugs and MDR levels are anyway thought to be modest. Whereas the first GFATM proposal focuses heavily on capacity building, the second proposal includes a large infrastructure and commodity component.
6. Issues	
Conflict	Progress towards global targets are outside the control of Government as large areas of the country are too insecure to develop effective services. Whilst progress is likely in terms of expanding DOTS, many believe that achieving global targets is unlikely and that whilst such targets are useful for advocacy purposes they are less useful in operational terms.
Lack of Government capacity to lead the partnership	The NTP is extremely weak and has been unable to lead the partnership process. This is not surprising as the national programme had been dormant for many years. As NTP is still in its infancy, WHO has been providing significant assistance to the extent that many see the national TB programme as the WHO programme. However, major capacity building initiatives are underway and a key challenge will be to withdraw external support as local capacity increases. Many have questioned whether Government is ready to move towards the contracted out model of providing district health services.
Weakness of health systems	<p>There are general health systems weaknesses:</p> <ul style="list-style-type: none"> too few, poorly distributed primary health care facilities mean a large part of the country is under served, especially in winter. Available facilities are in a poor state of repair referral systems are very weak. weak health management information systems low-levels of community involvement. counterfeit, low quality and unregistered medications freely available over the counter development assistance from donor agencies is not effectively coordinated. <p>Specific constraints relevant to TB include:</p> <ul style="list-style-type: none"> weak health sector infrastructure, including a lack of personnel weak NTP capacity due to staff shortages and poor training low community involvement in TB control coupled with high stigma about TB increasing private sector involvement without guidance on appropriate TB control
Weaknesses in financial management systems	Financial systems are extremely slow and bureaucratic. Attempts to bypass the Govt system through the creation of Grant and Contracts Management Units in line Ministries and Finance have run into similar problems. The Global Fund is unlikely to use MoH as the Principal Recipient. Negotiations are ongoing but it is likely that WHO or UNDP will act as an "incubator" supporting MOH until sufficient internal capacity is developed to take over.

Lack of resources and sustainability	Government's capacity to mobilise resources is low. Donors provide an estimated 90% of recurrent costs. The NTP is totally dependant upon donors for non-salary costs. Government contributes in the form of (low) salaries topped up by donors. Government is expected to make a greater contribution to salary and drugs costs but this will take time.
Lack of data / evidence	Data for decision-making is severely lacking. There are few laboratory facilities for making cultures so surveillance on drug resistance is difficult to achieve. There is a lack of data on the private sector. Operational research is needed for many issues e.g. access by women.
Major access problems	There are major access barriers. The terrain makes physical access extremely difficult in some areas and cultural factors have resulted in a major stigma being attached to TB and in an inability of women to leave the home to seek services
Lesson learned	The situation in Afghanistan is unique among the countries visited. The process of introducing and starting to build a TBCP based on DOTS in a situation like Afghanistan is an impressive achievement for WHO, the UN and the other partners. It may be that in such situations the emphasis should be on capacity building, and that ongoing progress towards the 2005 targets should be encouraged rather than their rapid achievement. Starting with reasonably accurate, but low case finding and outcome statistics, would an advantage, in that small improvements could more easily be demonstrated. Building partnerships in the field with communities may be an important process to build long-term sustainability.
Attribution	Neither WHO, NTP/MoH nor other partners draw any distinction between support through WHO and support through the STBP and see no reason to.

ANNEX E: STAFFING OF THE PARTNERSHIP SECRETARIAT

Title	Grade	Type of contract	Joined STBP	Contract end date	Time in STBP
1. Support & Innovation					
<i>Governance</i>					
Technical Officer	P4	Short term - 11 months (f)	25/10/99	27/11/04	4 years
Technical Officer – logistics	P2	Short term - 11 months	17/ 03/03	13/02/04	< year
<i>Coordination and Growth</i>					
Medical Officer	P5	Fixed term (s)	01/10/01	02/10/05	2 years
Secretary	G4	Short term - 11 months	15/04/02	12/03/04	1.5 years
<i>Working Groups</i>					
Scientist	P4	Fixed term (80%)	22/05/00	21/05/04	3.5 years
Medical Officer	P5	Fixed term (75%) (s)	22/01/03	19/12/03	< year
Secretary	G4	Short term - 11 months	23/04/03	30/07/04	< year
<i>Advocacy & Communications</i>					
Communications Advisor	P5	Short term - 11 months	22/04/02	19/12/03	1.5 years
Campaigns Officer	P4	Short term - 11 months	11/03/03	06/02/04	< year
Advocacy Officer GDF	P4	Short term - 11 months	<i>In progress</i>		
Advocacy Officer (to assist PF)	P2	Short term - 5 months	29/09/03	27/02/04	< year
Secretary	G4	Short term - 11 months	21/07/02	31/10/04	1.25 years
Secretary	G4	Short term - 11 months	<i>Vacant</i>		
2. Global Drug Facility					
GDF Manager	P5	Fixed term	<i>In progress</i>		
Operations Manager	P4	Short term - 11 months (f)	02/10/00	30/07/04	3 years
<i>Applications Review and Monitoring</i>					
Medical Officer – GLC	P4	Short term - 11 months (s)	20/10/03	17/09/04	< year
GDF Monitoring Officer	P4	Short term - 11 months	06/10/03	03/09/04	< year
GDF Applications & Review Officer	P2	Short term - 11 months	22/09/03	20/08/04	< year
Technical Officer	P2	Short term - 11 months	<i>In progress</i>		
Secretary	G4	Short term - 11 months	23/10/00	20/08/04	3 years
<i>Supply</i>					
Technical Officer	P5	Short term - 11 months (s)	01/10/02	13/08/04	1 year
Technical Officer – GLC	P3	Short term - 11 months	26/03/01	06/02/04	2.5 years
GDF Procurement & Supply Officer	P3	Short term - 11 months	11/10/03	13/02/04	< year
Secretary	G4	Short term - 11 months	07/09/02	29/06/04	< year
<i>Drug Management</i>					
Drug Management Officer	P5	Short term - 11 months (s)	<i>Vacant</i>		
<i>General Management and Support</i>					
Secretary GDF	G4	Short term - 11 months	<i>Vacant</i>		
Clerk	G3	Short term - 5 months	07/04/03	16/06/04	< year
3. General Management & Administration					
Executive Secretary	P5	Fixed term	13/10/03	19/06/04	< year
Partnership Resource Administrator	P5	Short term - 11 months	<i>In progress</i>		
Finance Officer	P3	Short term - 11 months (f)	09/01/02	19/06/04	1.75 years
<i>Information Management</i>					
IT Officer	P3	Short term - 11 months	06/10/03	03/09/04	< year
<i>General Administration</i>					
Assistant to Executive Secretary	G5	Fixed term	13/10/03		< year
Admin Assistant PER	G5	Fixed term	15/06/98	31/10/08	4.25 years
Secretary (to Exec Sec)	G4	Short term - 11 months	<i>Vacant</i>		

(f) request to convert to fixed term post submitted to MSU – process ongoing
(s) secondees from the American Thoracic Society, the Dutch Ministry of Foreign Affairs, Management Sciences for Health and Partners in Health, Harvard Medical School

ANNEX F: STOP TB PARTNERSHIP SECRETARIAT VACANCIES AND APPOINTMENTS / CONTRACT RENEWALS

The table in Annex E above shows that 21 short term contracts will expire in the period December 2003 – November 2004. The breakdown is shown below:

Month	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Total	2	0	5	1	0	0	3	2	3	3	1	1

The table below shows the vacancies and subsequent appointments as registered by the WHO Management Services Unit in the last 6 months for short term appointments, and for the most recent fixed term posts.

FIXED TERM		WHO80 Received	Vacancy Announced	Vacancy Closed	Finalized	Total time
P.06	Executive Secretary	14.03.03	04.07.03	27.05.03	05.09.03	6 months
P.03	Technical Officer	25.11.02	23.05.03	03.07.03		11 months +
P.04	Technical Officer	09.07.03				4 months +
SHORT TERM		WHO80 Received	Vacancy Announced	Vacancy Closed	Finalized	Total
P.02	Junior Advocacy Officer	06.08.03	17.09.03	22.09.03	01.10.03	8 weeks
P.04	Operations Manager	29.07.03	17.09.03	01.10.03		3 months +
P.02	Technical Officer	09.06.03	24.07.03	01.08.03	20.08.03	10 weeks
P.02	Technical Officer	24.06.03	24.07.03	08.08.03	08.08.03	6 weeks
P.04	Campaigns Officer	23.06.03	24.07.03	08.08.03	08.08.03	6 weeks
P.04	Technical Officer Monitoring	09.06.03	24.07.03	01.08.03	20.08.03	10 weeks
P.03	Information Technology Officer	24.06.03	29.07.03	05.08.03	06.10.03	14 weeks
P.05	Partnership Resource Administrator	07.07.03	11.08.03	06.09.03		4 months +

ANNEX G: PROPOSED BOARD PAPER FRONT PAGE

This paper by the [Secretariat]:

- reviews; and
- recommends

The cost would be \$x over [two] years.

The Board is asked to:

- approve the recommendation to
- take action to
- note that

Global Stop TB Partnership Coordinating Board [October 2003] Secretariat paper: Review of

Introduction:

ANNEX H: PLANNED AND ACTUAL PARTERSHIP SECRETARIAT EXPENDITURE 2002-5

	2002			2003			2004	2005
	Approved WP Budget	Income	Exp.	Approved WP Budget	Income as of 30 Sept 2003	Exp. as 30 Sept 2003	PROPOSED WORKPLAN	
Support and Innovations								
Governance	826,170	826,170	675,597	1,335,886	1,161,075	499,324	771,800	771,800
Coordination and Growth (Partnerships)	824,975	462,775	328,190	467,820	467,820	178,798	1,405,675	1,405,675
Working Groups	230,960	230,960	299,626	105,203	331,826	174,183	1,021,000	1,021,000
Global TB Alliance		996,505	1,136,898		1,251,575	1,251,575		
Communications and Advocacy	1,897,365	970,901	1,306,066	1,511,262	954,750	696,062	2,856,025	2,856,025
Sub-total for Support and Innovations	3,779,470	3,487,311		3,420,171	4,167,046		6,054,500	6,054,500
Global Drug Facility								
Application Review and Monitoring	468,500	425,389	185,083	564,774	564,774	67,378	1,714,675	1,714,675
Supply	23,400,800	6,959,354	11,823,719	41,386,927	13,556,212	507,591	26,992,120	40,488,180
Drug Management	109,330	107,800	107,800	202,722	53,900	59,949	106,800	106,800
General Management and Support	1,174,590	600,724	558,970	342,164	832,773	155,308	1,365,900	1,365,900
Sub-total for GDF	25,153,220	8,093,267		42,496,587	15,007,659		30,179,495	43,675,555
General Management and Administration								
Resource Mobilization and Financial Management	1,037,200	574,635	374,622	174,811	174,811	70,708	405,075	405,075
Information Management				499,008	230,610	145,245	291,650	291,650
General Administration	565,000	565,000	554,375	437,310	311,500	344,936	282,575	282,575
Sub-total	1,602,200	1,139,635	928,997	1,111,129	716,921	560,889	979,300	979,300

NOTE: EXPENDITURES FOR 2002 AND 2003 HAVE BEEN RECLASSIFIED ACCORDING TO THE NEW CLASSIFICATIONS
Adapted from update circulated at October CB

ANNEX I

PRINCIPLES FOR PARTNERSHIP ASSESSMENT

SIX PARTNERSHIP PRINCIPLES

From ASSESSING STRATEGIC PARTNERSHIP: THE PARTNERSHIP ASSESSMENT TOOL
By Brian Hardy, Bob Hudson and Eileen Waddington¹⁰

Principle 1: recognise and accept the need for partnership

- A. Identify principal partnership achievements.
- B. Identify the factors associated with successful partnership working.
- C. Identify the principal barriers to partnership working.
- D. Acknowledge whether the policy context creates voluntary, coerced or mandatory partnership working
- E. Acknowledge the extent of partners' interdependence to achieve some of their goals.
- F. Acknowledge areas in which you are not dependent upon others to achieve your goals.

Principle 2: develop clarity and realism of purpose

- A. Ensure partnership is built on shared vision, shared values and agreed service principles.
- B. Define clear joint aims and objectives.
- C. Ensure joint aims and objectives are realistic.
- D. Ensure that the partnership has defined clear service outcomes.
- E. Partners' reasons for engaging in the partnership are understood and accepted.
- F. Focus partnership effort on areas of likely success.

Principle 3: ensure commitment and ownership

- A. Ensure appropriate seniority of commitment.
- B. Secure widespread ownership within and outside partner organisations.
- C. Ensure sufficient consistency of commitment.
- D. Recognise and encourage individuals with networking skills.
- E. Ensure partnership working is not dependent for success solely upon these individuals.
- F. Reward partnership working and discourage/deal with those not working in partnership.

Principle 4: develop and maintain trust

- A. Ensure each partner's contribution is equally recognised and valued.
- B. Ensure fairness in the conduct of the partnership.
- C. Ensure fairness in distribution of partnership benefits.
- D. Ensure the partnership is able to sustain a sufficient level of trust to survive external problems which create mistrust elsewhere.
- E. Trust built up within partnerships needs to be high enough to encourage significant risk-taking.
- F. Ensure that the right people are in the right place at the right time.

Principle 5: create clear and robust partnership arrangements

- A. Transparency in the financial resources each partner brings to the partnership.
- B. Awareness and appreciation of the non-financial resources each partner brings to the partnership.
- C. Distinguish single from collective responsibilities; ensure they are clear and understood.
- D. Ensure clear lines of accountability for partnership performance.
- E. Develop simple, time-limited and task-oriented operational partnership arrangements.
- F. Ensure the prime focus is on process, outcomes and innovation.

Principle 6: monitor, measure and learn

- A. Agree a range of success criteria.
- B. Develop arrangements for monitoring and reviewing how well the partnership's service aims and objectives are being met.
- C. Develop arrangements for monitoring and reviewing how effectively the partnership itself is working.
- D. Ensure widespread dissemination of monitoring and review findings amongst partners.
- E. Celebrate and publicise partnership success and root out continuing barriers.
- F. Reconsider/revise partnership aims, objectives and arrangements.

¹⁰ Strategic Partnering Taskforce, Office of Deputy Prime Minister, UK, 2003

ANNEX J: WHO Direct Contributions to the Stop TB Partnership

WHO Contribution to the Stop TB Partnership Secretariat (2001-2002)			
	Year		Total
	2001	2002	
A. WHO Contribution to the Stop TB Partnership including GDF	US\$	US\$	US\$
WHO Technical Contribution			
Financed by WHO Regular Budget: Executive Secretary of the Secretariat (100%), Assistant to the Executive Secretary (100%), Director STB (50%) and partnership secretariat activities including monitoring of the Global Plan to Stop TB and development of materials for the World TB Day 2003	320,296	347,991	668,287
Financed by WHO contribution of unspecified voluntary funds: broad range of activities including advocacy and communications and partnership mobilization	1,249,080	1,438,992	2,688,072
Financed by other voluntary contributions: other staff in STB providing technical assistance support to the Partnership Secretariat	449,000	449,000	898,000
Total WHO Technical Contribution	2,018,376	2,235,983	4,254,359
WHO Administrative Support			
Office space and services (including electricity, telephone, security and IT support)	110,520	122,800	233,320
Management Support Unit services	216,000	240,000	456,000
Central (including budget & finance, staff financial services, treasury, human resources services, building management, conferences services and printing, procurement and legal services) (1)	710,167	406,429	1,116,596
Total WHO Administrative Support	1,036,687	769,229	1,805,916
Total of WHO Contribution to Stop TB Partnership including GDF	3,055,063	3,005,212	6,060,275
B. Programme Support Costs (PSC) generated from donor contributions for the Stop TB Partnership Secretariat			
Total Programme Support Costs (average rate 7.2%)	1,251,603	870,542	2,122,145

Notes:

(1) Administrative support costs are based on a cost formula agreed with other similar programmes such as The Special Programme for Research and Training in Tropical Diseases (TDR)

ANNEX K: FORMAT FOR SUMMARY BOARD REPORT ON GDF

This annex sets out a possible format for a 2 page report to be submitted to each Coordinating Board meeting. This is additional to the more detailed internal monitoring report

Highlights

Key developments, problems, and issues

Progress against performance indicators

a) Narrative Report

Providing information on key developments focusing on the following areas:

DOTS Expansion: setting out DOTS coverage pre and post GDF support number of countries which developed DOTS expansion plans and introduced policies based on the DOTS strategy, as part of the GDF application process. Number of countries, where following GDF support, new partners are providing additional technical and financial assistance for DOTS

Drug Management: setting out how drug management assessments as part of GDF Technical support have helped

Product Packaging: setting out how approaches adopted are assisting with drug management and access

Finances/Financial Management: setting out information on additional expenditure on TB in GDF from monitoring reports, value of GDF support (grant and direct procurement) current shortfall between commitments and funds, expected date of next procurement contract, timing and level of required funding for next procurement contract and comparison of GDF procured drugs with international guide price

b) Table

See overleaf

Indicators	Target	Time Period					Cumulative	Notes
		Jan- June 2002	July – Dec 2002	Jan- June 2003	July- Dec 2003	Jan- June 2004		
Access (\$m and % of Strategic Plan) Value of GDF support - grant supported - direct procurement Number of people treated with drugs supplied by GDF								
Lead Times - Application to Approval - Approval to Order - Order to Delivery No of GDF related Stock outs % of delivery dates for fast tracked emergency cases achieved								
Drug Quality and Rational Use -Proportion of global market for TB drugs produced by prequalified manufacturers - Proportion of DOTS patients treated with products on GDF product list - % of GDF drugs failing quality control procedures								
Order Completion % orders on time % orders complete % orders error and damage free % perfect order								
Drug Standardisation % of GDF clients are using 4FDCs % of countries have moved from non standard WHO regimens to WHO regimens as part of GDF support?								
Proportion of countries having an independent annual audit of TB programme performance								

ANNEX L: GDF COMPREHENSIVE MONITORING REPORT

Period:

Summary Information for period:

Brief narrative overview of Key service areas since previous report

Grant Service

- Applications and Review: Number of applications now approved. Status of next Technical Review Committee meeting. Update on GDF country visits
- Mayetic Village: Update on this tool.

Procurement

- Deliveries of TB drugs: Countries which have received drugs in the period.
- Procurement Agent: Update on contractual relations with procurement agent, QA agent.
- Upcoming tenders / RFPs

Prequalification of manufacturers of TB products

- List of pre-qualified suppliers / products: Update on 'white list' progress, status of work with WHO/EDM, update on site visits.

Products

- Patient kits: Update on patient kits, blistered products, FDCs and any new products which have entered the GDF catalogue.

Direct Procurement Service

- Update on this service line; orders placed and contracts agreed.
- GFATM countries using this service area.

Monitoring Service

- Overview of countries monitored and approved for a second year of GDF support (for grant and DP countries) changes to this process.
- Upcoming RFPs and contractual relations with desk auditors

Drug Management, Technical Assistance and Capacity Building

- Overview of progress in this area.

Advocacy and Communications

- Overview of progress in this area

External Relations

- Overview of collaboration with GFATM, STB Partners, WHO and private sector.

Governance, Management and Financing Mechanisms

- External and internal evaluations
- Information management and internal management update
- MoU with WHO
- Financing Mechanisms: Current financial situation.

Table 1: GDF Performance Indicators for this period:

GDF Core Functions	Activity	Reporting period	Previous reporting period
Grant making	Total patients granted to date (and % vs target as per strategic plan) ⁱ	No, %	No, %
	Total \$ raised to date for grant making (and % vs target as per strategic plan) ⁱⁱ	\$, %	\$, %
	Total value of grants approved to date (including buffer) ⁱⁱⁱ	\$	\$
	Total number of patient treatments approved (including buffer) via grants ^{iv}	Pts	Pts
	Total financial shortfall to cover existing commitments	\$	\$
Direct Procurement ^v	Number of applications approved for Direct Procurement	No.	No.
	Total value of Direct Procurement Orders	\$	\$
	Total number of patients approved (including buffer) via direct procurement	Pts	Pts
Applications and review ^{vi}	No. of high burden countries aware of possibility of applying to GDF (measures awareness of application)		
	TRC meetings completed vs target as per workplan		
	No of rounds of applications and review	No.	No.
	No of applications for GDF support ^{vii}	No.	No.
	Number of applications approved for support	No.	No.
	Applications rejected		
	Applications accepted that were previously rejected or placed under consideration		
	Average time from receipt of application to grant agreement	Days	Days
Monitoring & Evaluation ^{viii}	Number of applications monitored for repeat support	No.	No.
	Customers perceptions on usefulness and quality of M&E		
	Partners and donor perceptions on quality and usefulness of M&E		
	Number of applications accepted for repeat support	No.	No.
	No. of countries that have received formal feedback from GDF		
	% GDF countries receiving TA for drug management/Technical Assistance as part of GDF monitoring	%	%
	% Monitoring missions on time	%	%
White List and Supplier mobilisation ^{ix}	Number of companies on WHO/GDF white list	No.	No.
	Number of companies applying to join white list	No.	No.
	Number of companies in High burden countries applying to join	No.	No.
Procurement ^x	Number of applicants which have received drug deliveries	No.	No.

	Average lead time from placing order to receipt of drugs in country (excluding countries which asked for delayed deliveries)	Days	Days
	No of countries receiving drugs within agreed lead time (5 months after GA) ^{xi}	No.	No.
	Drug orders placed	No.	No.
	GDF countries using track and trace	No.	No.
	Total units per product delivered	No./product	No./product
	Orders on-time	%	%
	Orders complete	%	%
	Orders error and damage free	%	%
	Perfect order achievement ^{xii}	%	%
	Average Time taken for GDF drugs to clear customs & registration	Days	Days

Table 2 GDF Impact Indicators for this period:

Area	Indicator	Reporting period	Previous period
Procurement	No countries which stocked out because GDF drugs did not arrive on time ^{xiii}		
	No countries running on buffer stocks		
	% GDF countries using track and trace		
Direct Procurement (Affordability) ^{xiv}	Direct procurement price as a percentage of prices that GDF countries were buying at previously		
	Quality ^{xv}	% GDF drugs of known good quality ^{xvi}	
		% GDF batches that were rejected by pre shipment quality control	
Drug management ^{xvii}	% GDF batches recalled in country i.e. failed in-country quality control		
	% of GDF countries with stock out at national, intermediate or peripheral levels		
	% GDF countries with out of date drugs		
Standardization ^{xviii}	% GDF countries which followed up on at least 50% of DM recommendations, as part of GDF monitoring		
	No. of countries adopting WHO recommended treatment regimens after GDF support (if not using before)		
	No of countries introducing FDCs through GDF support		
	No countries using 4FDC through GDF support		
	No. countries using blistered products with GDF support		
DOTS Expansion ^{xix}	No. countries using patient kits with GDF support		
	Global % increase in DOTS coverage since GDF support		
	No. of countries which introduced DOTS or developed a DOT Expansion Plan due to GDF support		
Cure Rates ^{xx}	Estimated number of TB patients cured with GDF drugs ^{xxi}		
	Actual number of TB patients cured with GDF drugs		
Drug Prices ^{xxii}	GDF prices in comparison to World International price (per product)		

	Average cost per additional cure in US dollars ^{xxiii}		
	Price as a % of previous drug price that the country was buying at.		
Political commitment/ additionality/ GDF Terms and Conditions ^{xxiv}	% countries which have complied with all GDF terms and conditions of support		
	% of countries which implemented recommendations from country visits or TRC		
	Annual change in Govt. expenditure on NTP post GDF support (actual amount & percent)		
	New commitments from Governments of GDF countries	\$	\$
Partner mobilisation ^{xxv}	New partners introduced, following GDF support (no. of countries)		

Board Report Endnotes

- i Source = strategic plan and GDF monitoring spreadsheet
- ii Source = strategic plan and GDF financial spreadsheet
- iii Source = GDF monitoring spreadsheet.
- iv Approved for first year/second year/third year by CB
- v Source = GDF monitoring spreadsheet, country spreadsheet
- vi Source = GDF monitoring spreadsheet and workplan
- vii A country that applies, is not approved and reapplies is considered as one country but two applications. A country that applies for emergency support and regular support is also considered as one country, but two applications. A second year of support is not considered as a new application.
- viii Source = Desk audit reports, GDF monitoring spreadsheet, GDF ARM country spreadsheet.
- ix Source = WHO/EDM
- x Source = IAPSO and GDF monitoring spreadsheet
- xi Source of data = GDF internal monitoring spreadsheet and IAPSO track and trace website.
- xii The "perfect order" indicator measures the completeness, quality and timeliness of the orders. The perfect order is a logistics management tool based on:
- On-time delivery
 - Order completeness
 - Freedom from error and damage
- Perfect order achievement = % on-time x % complete x % error free of all orders.
- xiii Source of data = GDF desk audit report/monitoring mission checklist.
- xiv Source of data = GDF desk audit report for DP countries
- xv Source of data = GDF monitoring checklist and SGS
- xvi Known good quality defined as defined as manufacturers producing drugs under oversight of a competent regulatory authority.
- xvii Source = GDF audit report and monitoring mission report.
- xiii Source = IAPSO report and GDF applications data
- xix Source = WHO annual report, applications material and GDF monitoring checklist
- xx Source of data = GDF desk audit report
- xxi 85% of total patients to be treated with GDF drugs (not including buffer). The figure is derived from the estimated cure rate of 85 % - the official global target for TB control.
- xxii Source = MSH price indicator guide, GDF drug market surveys.
- xxiii Cost per estimated patient cured, excluding buffer.
- xxiv Source of data = GDF audit report and monitoring mission report.
- xxv Source of data = GDF applications material and monitoring report

ANNEX M: GLOBAL FINANCIAL MONITORING FRAMEWORK

Global Plan to Stop TB Financial Monitoring Framework			Expenditure Previous Yr 2000-2003	Projected contribution 2004-2005	Estimated requirement 2000-5	Projected shortfall	Projected requirement 2005-10	
Domestic (funds from the country, high burden countries only)	Public	Central Government						
		Local Government						
	Private	Local Non Profit						
		Local (for profit)						
		Patient Contributions						
External (funds from outside High Burden Countries)	Global: activities at global level: research, coordination, advocacy, resource mobilisation, alliance building	Public	Multilateral					
			Bilateral					
			GFATM					
			STB Partnership					
			Other					
		Private	Corporations					
			NGOs					
			Technical consulting firms					
	Foundations							
	Regional (for regional level activities)	Public	Multilateral					
			Bilateral					
			Other					
		Private	Regional (non profit)					
			Regional (for profit)					
	National (contribution made at the country level)	Public	GFATM					
			Multilateral					
			Bilateral					
			GDF					
			STB Partnership					
			Other					
Private		Local (non profit)						
		Local (for profit)						

ANNEX N: SUGGESTED FORMAT FOR FINANCIAL REPORTING

		FUNDING SOURCES		
BROAD THEMES	KEY PROGRAMME	Through WHO	Trust Fund	Other
Partnership Coordination	Governance of Global Partnership to Stop TB			
	STOP TB Working Groups and Cross Cutting Initiatives			
	Global Plan to Stop TB			
	Mobilise Resources and increase investment in TB			
	Expansion and coordination of the Global Partnership			
	Strategic Framework: Advocacy and Communications			
	International Campaign: Countdown to 2005 Global TB Targets			
	World TB Day			
	Public Awareness and Information Dissemination			
	Resource Centre			
Stop TB Partnership Secretariat	Office Management			
	Office Administration			
Global Drug Facility	An expanded applications and review mechanism			
	Drugs delivered to eligible countries			
	White list of pre-qualified manufacturers			
	Monitoring mechanism			
	Sustained financing			
	Awareness and support for GDF			
	GDF Administration			

ANNEX O: BIBLIOGRAPHY

During the evaluation, the team examined the full range of Stop TB Partnership documentation, including The Basic Framework for the Global Partnership to Stop TB; The Global Plan to Stop TB; documentation of the Coordinating Board, Working Committees, Working Groups and Task Forces; Secretariat documentation including GDF material, memoranda of understanding, financial and performance reports, meeting reports and website material. The following is a selected list of some of the other key reference documents:

TUBERCULOSIS

Reports

McKinsey & Company. Evaluation of the Global TB Drug Facility, Final Report. Stop TB Partnership / WHO. April 2003.

World Health Organisation. WHO Report 2003: Global Tuberculosis Control: Surveillance, Planning, Financing, 2003. WHO/CDS/TB/2003.316

World Health Organisation. Report of the 1st *ad hoc* Committee Meeting on the TB Epidemic: London 17-19 March 1998. WHO/TB/98.245

World Health Organisation. Implementing Global TB Control: Solutions to DOTS Expansion Constraints. Report of the 2nd *ad hoc* Committee on the TB Epidemic. A Companion to the Global Plan to Stop TB, 2003

World Health Organisation, Roll Back Malaria. Framework for Monitoring Progress and Evaluating Outcomes and Impact, 2000. WHO/CDS/RBM/2000.25

World Health Organisation. Towards a TB-Free future, 2001. WHO/CDS/STB/2001.13.

Articles / Papers

WHO Bulletin June 2002 (Vol 80, No 6) TB Special (coordinated by Mario Raviglione with Williamina Wilson)

Directly observed treatment for tuberculosis; less faith, more science would be helpful, Garner P and Volmink J, British Medical Journal, October 11, 2003, Volume 327, p.823-824

International Group of Health Experts Issues: Global "Declaration to Stop TB", Banta D, Journal of the American Medical Association, May 10, 2000 – Vol 283, No.18, p.2375-2377

Problems and Solutions for the Stop TB Partnership, Blower SM and Daley CL, The Lancet Infectious Diseases, Vol 2, June 2002

The economics of TB control in developing countries, Walker D and Stevens W, Expert Opinion Pharmacoeconomics. 2003 4(3): 359-368

The politics of 'branding' in policy transfer: the case of DOTS for tuberculosis control, Ogden J, Walt G and Lush L, Social Science & Medicine, 57 (2003) 179-88

Treatment of tuberculosis; concordance is a key step, Maher D, Uplekar M, Blanc L and Raviglione M, British Medical Journal, October 11, 2003, Volume 327, p.822-823

OTHER INITIATIVES / MECHANISMS

Reports were also reviewed on other initiatives and mechanisms, including the Global Fund for AIDS, TB and Malaria (GFATM), the Global Alliance for Vaccines and Immunisation (GAVI), Roll Back Malaria (RBM), and the Polio Eradication Initiative (PEI). These included Board papers and reports, teleconference notes, website material and other documentation. Selected key references are given below:

Overall

McKinsey & Company. Developing Successful Global Health Alliances. Bill & Melinda Gates Foundation, April 2002.

Nuffield Institute for Health and Strategic Partnering Taskforce. Assessing Strategic Partnership: The Partnership Assessment Tool. Office of the Deputy Prime Minister, July 2003.

GFATM

GFATM. Third Meeting of the Transitional Working Group to establish a Global Fund to fight AIDS, Tuberculosis and Malaria, Brussels, 13-14 December 2001: Final Report and 'Decisions Adopted' Papers

Global Health: GFATM has advanced in key areas, but difficult challenges remain. United States General Accounting Office (GAO), May 2003.

IHSD Discussion Paper, Governance Issues: Global Fund for Aids, Tuberculosis and Malaria, October 2001

Towards Monitoring and Evaluating the System Wide Effects of the Global Fund to Fight AIDS, Tuberculosis and Malaria: A Conceptual Framework. Prepared for a Workshop on the System-Wide Effects of the GFATM, Geneva, 2-3 June 2003. Bennett S and Fairbank A, Partners for Health Reform *plus* Project

GAVI

GAVI Secretariat. GAVI Strategic Framework 2004-5, 22 July 2003

GAVI Board Sub-Group Review of Task Forces, July 2003. Paper to 11th GAVI Board Meeting

GAVI. Proposal for Improved GAVI Board Operations, July 2003. Paper to 11th GAVI Board Meeting

RBM

Malaria Consortium. Final report of the External Evaluation of Roll Back Malaria. Achieving Impact: Roll Back Malaria in the Next Phase, August 2002

PEI

Polio Eradication Initiative Evaluation Report

ANNEX P: REPORT ON THE MEETING OF THE SECOND *AD HOC* COMMITTEE ON THE TB EPIDEMIC: RECOMMENDATIONS TO STOP TB PARTNERS

MONTREUX, SWITZERLAND, 18-19 SEPTEMBER 2003¹¹

Contents

Global targets for TB control

List of abbreviations

Introduction

Recommendations

1. Consolidate, sustain and advance achievements
2. Enhance political commitment
3. Address the health workforce crisis
4. Strengthen health systems, particularly primary care delivery
5. Accelerate the response to the TB/HIV emergency
6. Mobilise communities and the corporate sector
7. Invest in research and development to shape the future

Conclusion: next steps

Annex: Members of the second ad hoc Committee on the TB epidemic

¹¹ The 2nd *ad hoc* Committee is convened under the auspices of the DOTS Expansion Working Group (one of six working groups under the Global Partnership to Stop TB).

Global targets for TB control

World Health Assembly 2005 targets¹²

- to detect 70% of smear-positive cases
- to treat successfully 85% of all such cases

G8 Okinawa 2010 targets

- to reduce TB deaths and prevalence of the disease by 50% by 2010

Millennium Development Goals 2015 targets

- Goal 6 Target 8: to have halted by 2015, and begun to reverse, the incidence of priority communicable diseases, including TB (see Millennium Development Goals indicators 23 and 24)

List of abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral treatment
CCM	Country Coordinating Mechanism
DEWG	DOTS Expansion Working Group
DOTS	The global strategy to control TB
GDF	Global TB Drug Facility
GFATM	Global Fund to Fight AIDS, TB and Malaria
GLC	Green Light Committee
GPSTB	Global Plan to Stop TB
HBC	High-burden country
HIPC	Highly Indebted Poor Countries
HIV	Human Immunodeficiency Virus
HR	Human Resources
ILO	International Labour Organization
MDGs	Millennium Development Goals
MTEF	Medium-Term Expenditure Framework
NICC	National Interagency Coordinating Committee
NGO	Non-Governmental Organization
NTP	National Tuberculosis Programme
OECD	Organization for Economic Cooperation and Development
PRSP	Poverty Reduction Strategy Paper
SWAP	Sector-wide approach
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint UN Programme on HIV/AIDS
VCT	Voluntary Counselling and Testing (for HIV)
WHA	World Health Assembly
WHO	World Health Organization

¹² In 1991, a WHA resolution proposed that all countries adopt two TB control targets for the year 2000: to detect at least 70% of all new infectious cases and to cure at least 85% of those detected. During the second half of the 1990s, it became apparent that the year 2000 targets would not be met on time. Thus, WHO convened the 1st *ad hoc* Committee on the TB Epidemic in London in 1998, which made a number of recommendations to strengthen the various elements of the DOTS strategy and accelerate impact. The WHA decided in 2000 to postpone the targets initially set for 2000 until 2005.

Introduction

With 8.5 million new cases and nearly 2 million deaths annually, the global TB epidemic has reached an unprecedented scale. Urgent and effective action is necessary to ensure that all those suffering from TB have access to effective care. Setting the mid-term strategic direction for global TB control requires review of progress so far in implementing TB control and analysis of constraints to further progress. Under the auspices of the DOTS Expansion Working Group (DEWG), the 2nd *ad hoc* Committee on the TB epidemic has reviewed progress in global TB control, examined constraints to improved TB control in high-burden countries (HBCs) and sought solutions to these constraints through a wide consultative process during 2003. The results of this work are set out in a background document covering fifteen themes, of which five were the subject of consultations held in 2003 (on widening the partnership, social mobilisation and advocacy, primary care providers, health system reform and human resources).

The Committee met in Montreux, Switzerland, from 18-19 September 2003, to finalise its recommendations. The target audience of the Committee's report consists of Stop TB partners and others committed to communicable disease control, poverty reduction and development. The Committee sees the main challenge for global TB control as expanding TB control activities across all health care providers and other stakeholders within the health sector, and across a broader range of stakeholders in sectors beyond health.

The United Nations (UN) Millennium Development Goals (MDGs) provide an unprecedented framework and opportunity for international cooperation in redressing the global injustice of poverty, including improving the health of the poor. The Committee recognises health as both a human right and a factor contributing to poverty reduction. The Committee acknowledges the MDGs' global strategic perspective and importance of regional approaches towards meeting the goals, since the rate of progress towards meeting the MDGs varies among regions. For example, based on current trends, sub-Saharan Africa will not meet the poverty or health MDGs until half way through the next century. Translating the global perspective into country action and accelerating progress towards targets depends on regional and national Stop TB partnerships.

Progress in TB control can contribute to improved health and poverty reduction, and depends on actions which are beyond the specifics of TB control. Thus the Committee views TB control as an integral part of the broad strategy for improving health and reducing poverty. **This implies that for further progress in TB control, the TB constituency must reach out to the broader constituency of governments and agencies committed to accelerating health improvement and poverty reduction. This broader constituency must also support TB control as part of it's contribution to achieving the MDGs.**

The Committee made recommendations under seven headings (many of which cut across the different aspects of TB control): 1) consolidate, sustain and advance achievements; 2) enhance political commitment (and its translation into policy and action); 3) address the health workforce crisis; 4) strengthen health systems, particularly primary care delivery; 5) accelerate the response to the TB/HIV emergency; 6) mobilise communities and the corporate sector; 7) invest in research and development to shape the future.

Recommendations

1. Consolidate, sustain and advance achievements

The issue

Sustained and enhanced support is necessary to consolidate and enlarge upon the substantial achievements in global TB control since the 1st ad hoc Committee met in 1998. These achievements include the establishment of the Stop TB Partnership, the development of the Global Plan to Stop TB, the creation of the Global TB Drug Facility (GDF) and the Green Light Committee (GLC) of the DOTS-Plus Working Group, and the mobilisation of increased funding for TB control from sources including the Global Fund to Fight AIDS, TB and Malaria (GFATM). This consolidation provides the basis for further progress in these areas and progress in developing other key recommendations and areas of activity.

General recommendation

The Stop TB Partnership should demonstrate to the donor community and TB endemic countries the effectiveness and value added of the Stop TB Partnership, GDF, GLC and the Partnership's collaboration with the GFATM. The Partnership should capitalise on the initial success of these initiatives in advocating for the support necessary to maintain and enhance their contribution to achieving global TB control targets, in support of progress towards the MDGs and poverty alleviation.

Specific recommendations

The Stop TB Partnership should:

- establish, broaden, energise and cross-fertilise activities with a wider range of stakeholders using available mechanisms at global, regional and national level, where opportunities for strengthening country-level partnerships include National Inter-Agency Coordination Committees (NICCs), Sector-Wide Planning and Coordinating Committees, and Country Coordinating Mechanisms (CCMs);
- strengthen the working relationship with the GFATM by establishing a joint GFATM-Partnership standing committee;
- negotiate with the GFATM to a) ensure the success of GFATM support to grantees, and b) build on the current arrangements for procurement of second-line TB drugs through the GLC to position GDF as a preferred first-line TB drug facility of the GFATM;
- seek enhanced and sustained donor support for GDF operations (e.g. technical assistance to countries in drug management and monitoring) and grant function, while continuing to fully explore support for the GDF's direct procurement function;
- advocate for support for TB programme activities using information obtained by defining and monitoring how health system reform policies and Mid-Term Expenditure Frameworks (MTEFs) contribute to health-related MDGs.

2. Enhance political commitment

The issue

The Committee urges intensified efforts to enhance political commitment to TB control (through global advocacy, communications and social mobilisation) and its translation into policy and action, to maintain momentum and speed up progress towards the 2005 targets and the 2015 MDGs. While seeking continued support from bilateral development assistance agencies and multilateral organizations (e.g. the World Bank), the Committee welcomes the opportunity provided by the GFATM to scale up resources available to tackle major diseases, including TB, and supports its role both in leveraging more resources and in promoting coordination.

General recommendations

a) The Stop TB Partnership should explore complementary “top-down” (i.e. led by policy and decision makers) and “bottom-up” (i.e. community-led) approaches to consolidate and raise the position of TB on the development agenda.

b) The Stop TB Partnership should advocate for levels of TB funding which are commensurate with the global burden of TB. This entails seeking financial support for TB control from increased donor resources, by broadening the partnership base to include non-traditional funders, and by catalysing additional national allocations. Funding from this wide range of sources, including the GFATM, should be reliable, predictable and additional to what would otherwise have been funded.

Specific recommendations

a) The Stop TB Partnership should adopt the 2015 Millennium Development Goal 6 target 8 which pertains to TB and represents an impact target, while retaining the World Health Assembly (WHA) 2005 targets as process targets without which it will not be possible to reach the impact targets.

b) Ministries of Health in countries badly affected by TB should ensure dedicated budget lines for TB control activities.

c) The Stop TB Partnership should work with countries submitting proposals to the GFATM to ensure that the proposals fully reflect national financial needs for TB control and are poverty-focused.

d) The Stop TB Partnership should assist Ministries of Health to address TB control needs as part of poverty reduction strategies and efforts to strengthen health systems.

e) The Stop TB Partnership should explore the following “top-down” approaches to enhancing political commitment and its translation into policy and action:

- lobbying of the highest authorities in national governments, international organizations and the donor community through the WHA, the WHO regional committees, and other global gatherings, especially those related to MDGs and GFATM;
- country by country “political mapping” and analysis of constraints to progress in TB control, and of reasons for successes and failures;
- high-level missions to TB endemic and donor country authorities by Stop TB Partnership representatives;

f) The Stop TB Partnership should explore the following “bottom-up” approaches to enhancing political commitment through mobilisation of communities and societies at national and sub-national level:

- supporting countries to develop a specific advocacy, communications and social mobilisation plan as part of the NTP’s DOTS expansion plan and to strengthen local partnerships;
- supporting countries to pursue capacity building for advocacy, communications and social mobilisation at subnational and local levels;
- supporting countries to develop information systems which include, in addition to epidemiological and NTP coverage indicators, indicators on advocacy, communication and social mobilisation to monitor and evaluate the impact of these activities;
- developing clear guidelines on advocacy, communications and social mobilisation in collaboration with WHO and other technical agencies, to enable NTPs to rapidly adapt and incorporate these activities in annual action plans;

- strengthening its advocacy, communications and social mobilisation efforts, e.g. by instituting and supporting a specific working group within the Stop TB Partnership and with representation on the Partnership's Coordinating Board.

3. Address the health workforce crisis

The issue

Economic growth depends on assuring and maintaining the health of people, which in turn depends on a healthy, motivated and qualified workforce to deliver prevention and care, accessible to those in need. In many developing countries, health workforce limitations in number, skills, effectiveness and distribution constrain the delivery of effective health care, including high-quality and high-coverage implementation of the DOTS strategy. Many factors underlie these limitations, including administrative barriers to creating and filling posts, an unhealthy work environment, stagnant employment mechanisms, HIV-related illness and death among health care workers in high HIV prevalence countries, and inadequate pay, conditions of service and career opportunities. These problems may cause health workers to leave their jobs in the health sector in general, or the government service in particular, for better opportunities elsewhere.

General recommendation

The Stop TB Partnership should collaborate with national governments and international bodies to promote the development of policies aimed at a) removing administrative barriers to creating and filling posts and b) promoting terms and conditions of service in the health sector that are attractive to employees. Such policies should cover career opportunities, ongoing training, work conditions, incentive schemes and effective prevention and health care services for the health workers themselves.

Specific recommendations

The Stop TB Partnership should

- collaborate with the relevant Ministries (e.g. Health, Planning, Education) to promote the assessment of human resource (HR) needs in the health sector in general and for TB control in particular;
- assist Ministries of Health to address HR needs as part of poverty reduction processes, e.g. poverty reduction strategy papers and debt relief through the Highly Indebted Poor Countries (HIPC) Initiative;
- collaborate with governments, financial partners and technical assistance agencies to support the necessary HR planning and training as identified through the analysis of HR needs;
- explore with all stakeholders strategies for further mobilising HR for TB control from the full range of primary care providers, especially community groups and grassroots NGOs;
- urgently explore with all stakeholders specific strategies in countries severely affected by HIV the mobilisation of HR to address priority diseases of poverty, including TB.

4. Strengthen health systems, particularly primary care delivery

The issue

TB control requires sustained commitment at all levels to implement sound, evidence-based policies. The Committee recognises that many constraints to improved TB control relate to underlying weaknesses and under-financing of health systems. The Committee advises prioritisation of TB within the health system commensurate with its disease burden. The aim of health system reform is to develop strong, effective and equitable health services which achieve priority health outcomes (including TB) and which are accountable to consumers. Health gains through reform will facilitate the articulation of the case for a share of national

resources that is adequate to ensure equitable health systems. Strong health information systems are crucial to guide policy and evaluate disease control progress.

General recommendations

The Stop TB Partnership should promote collaboration among NTP managers, health policy and decision-makers and those implementing health system reform to:

- ensure that TB control programmes contribute to and build upon broader approaches to health system strengthening and link with other public health interventions;
- enable reflection of TB control needs in the design and implementation of health reform strategies, sector programming and in MTEFs;
- stimulate accountability and monitoring regarding the contribution of health system policies towards achieving the health-related MDGs.

Specific recommendations

a) The Stop TB Partnership should foster NTP stewardship capacity (as part of national stewardship of health activities) to equip NTPs in their role to guide, manage and coordinate the provision of TB care by the full range of health care providers (including all Ministry of Health and other governmental facilities, NGOs, employers, private practitioners, religious organizations and community groups).

b) The Stop TB Partnership should support NTPs in harnessing contributions by all primary health care providers to TB case finding and cure, through the following actions:

- surveying the range of primary providers and their capacity;
- strengthening links between the formal primary care system and community groups;
- involving as many grassroots groups as possible (e.g. local NGOs and community organizations) with common aims, objectives, strategies and policies,
- developing Terms of Reference for all primary providers and other partners in national DOTS expansion plans.

c) The Stop TB Partnership should encourage the partners in the Global TB Monitoring and Surveillance project to:

- intensify collaboration with those groups involved in monitoring and surveillance of other priority public health problems, e.g. HIV/AIDS and malaria;
- intensify improvements in accuracy of estimates of progress towards TB targets, by strengthening regional and national capacity in monitoring and surveillance.

5. Accelerate the response to the TB/HIV emergency

The issue

The TB/HIV emergency demands an urgent and effective response. Many high HIV prevalence countries are struggling to cope with HIV-fuelled TB. They face the challenges of tackling rising TB incidence and improving sub-optimal treatment outcomes. The main consideration from the TB control perspective is that, as a result of the HIV epidemic, full implementation of the DOTS strategy alone is unlikely to result in declining TB incidence in the nine HBCs in sub-Saharan Africa. This holds true even if these countries would eventually meet the WHA 2005 targets in 2010. Forcing the rising TB incidence downwards requires accessible delivery of the full, integrated strategy of expanded scope to control HIV-related TB. This strategy is defined in the "Strategic framework to decrease the burden of TB/HIV" (developed by the WHO Stop TB and HIV/AIDS Departments and endorsed by the TB/HIV Working Group on behalf of the Stop TB Partnership). Key elements of the strategy include interventions against TB, e.g. intensified case-finding and cure and TB preventive treatment, and interventions against HIV (and therefore indirectly against TB), e.g. condoms, treatment of sexually transmitted infections, and antiretroviral treatment (ART).

General recommendation

The Stop TB Partnership and HIV/AIDS partnerships, e.g. those linked to the WHO HIV/AIDS Department and to the joint UN programme on HIV/AIDS (UNAIDS), should urgently step up collaboration to deliver the strategy of expanded scope to control HIV-related TB. Collaboration between TB and HIV/AIDS partnerships should involve the identification of areas of mutual benefit and reflect their comparative advantages.

Specific recommendations

The Stop TB Partnership and HIV/AIDS partnerships should collaborate to support countries in full implementation of the WHO interim policy on collaborative TB/HIV activities, including:

- speeding up progress towards achieving the “3 by 5” goal (3 million people on ART by 2005) by making ART available to HIV-positive TB patients;
- encouraging those responsible for ART delivery to apply lessons learned from TB programmes in the application of sound public health principles to large scale diagnosis and treatment of TB as a chronic communicable disease, and NTPs to apply lessons learned from HIV programmes in social mobilisation and advocacy.

6. Mobilise communities and the corporate sector

The issue

The main focus of TB control activities has traditionally been on government health service providers. Speeding up progress towards global TB control targets requires mobilisation of sectors and groups beyond designated government health service providers. The community must be part of the solution to challenges in TB control. Ways of engaging community groups and new sectors such as the corporate sector are likely to be different from the ways of engaging government health service providers. The conduct of the dialogue which the TB community has had with government health services is in line with the procedures of government authority. However, effective dialogue between the Stop TB Partnership and partners in domains other than the government health sector requires a change in the way the dialogue is conducted.

General recommendations

a) The Stop TB Partnership should intensify efforts to engage the widest possible range of stakeholders within the health sector and other sectors at global, regional and national levels, to contribute to TB control activities, e.g. civil society groups, employers, representatives of groups of TB patients and HIV activists, the broad HIV/AIDS constituency, the education sector and key multilateral organizations, e.g. the International Labour Organization (ILO).

b) The Stop TB Partnership should engage with the private (corporate) sector through a dialogue that recognises mutual objectives in advancing human and economic development.

c) The Stop TB Partnership should engage with community groups through a dialogue conducted in line with the principles of participatory community development.

Specific recommendations

a) The Stop TB Partnership should support NTPs through Ministries of Health to incorporate the mobilisation of grassroots community groups as an essential part of the strategy to articulate demand for improved health care, including effective TB control.

b) The Stop TB Partnership should explore ways of increasing collaboration with the corporate sector through:

- greater corporate sector involvement in Partnership institutional arrangements and ways of working;

- development, articulation and dissemination of arguments for corporate sector involvement in TB control, e.g. the economic and social benefits of corporate sector activities in contribution to TB control;
- promotion of links with established corporate sector activities in health, especially in HIV/AIDS programmes;
- incorporation of TB activities in the development of corporate sector health activities.

7. Invest in research and development to shape the future

The issue

In the short term, it is necessary to scale up research to determine the best ways to implement and monitor the impact of current interventions of proven effectiveness. Capacity for this operational research is an essential component of NTP activities. In the longer term, there is a need for new tools to assist in achieving the goals of the Global Plan to Stop TB (GPSTB), e.g. a more effective vaccine, better diagnostic tests and preventive and therapeutic approaches. Given the current level of activity in these areas of research and their relevance to global TB control, the Stop TB Partnership Working Groups on new vaccines, diagnostics and drugs must develop close collaborative relationships primarily with the DEWG but also with the other two implementation working groups (on drug-resistant TB and TB/HIV).

General recommendation

The Stop TB Partnership should ensure the framework in which the working groups promoting the development of new tools can interact effectively with the DEWG and the other two implementation working groups, to align the opportunities provided by the research community with the needs of TB control service providers.

Specific recommendations

a) The Stop TB Partnership should work with the research community:

- to advocate for new tools;
- to lobby research funding agencies for increased financing of TB research;
- to lobby pharmaceutical companies for increased involvement and investment in TB research;
- to clearly define the characteristics required for useful tools;
- to clearly define the economic justifications and social benefits for the development of new tools;
- to foster partnerships between researchers and trial sites, particularly in developing countries.

b) The Stop Partnership should promote the operational research necessary to: (i) address constraints to patient demand and participation in TB care and control; ii) ensure maximum contribution to TB control of the full range of health care providers, e.g. local NGOs and other community groups, private practitioners, employer health services; and (iii) assess progress in ensuring the equitable distribution of coverage by the DOTS strategy across all socioeconomic groups.

c) The Stop TB Partnership Coordinating Board should develop and articulate arguments in favour of building increased research capacity to encourage Organization for Economic Cooperation and Development (OECD) countries to increase their funding for this activity.

Conclusion: next steps

The DOTS Expansion Working Group and Stop TB Partnership Coordinating Board endorsed the second *ad hoc* Committee's report at their meetings in The Hague on 7-8 October and 10 October 2003 respectively. The Stop TB Partnership secretariat will ensure wide dissemination of the report and the background document prepared for the Committee meeting and coordinate the process of identifying the main stakeholders responsible for putting into action its recommendations. This will involve all the Stop TB Partnership Working Groups. The Stop TB Partners' Forum in New Delhi early in 2004 provides the opportunity for all partners to indicate their contribution to putting the recommendations into action. The report will feed into the work of the Millennium Development Goals Project and to the revision of the GPSTB. As the lead UN agency for health, WHO has a particular role in disseminating the report to the governments of the UN member states, through the WHO regional offices.

Annex: Members of the second ad hoc Committee on the TB epidemic

Dr N Billo, International Union Against Tuberculosis and Lung Disease, Paris, France
Dr A Bloom, United States Agency for International Development
Dr J Broekmans, Royal Netherlands Tuberculosis Association (2nd *ad hoc* Committee Chair)
Dr M Dayrit, Secretary for Health, Philippines
Ms F Dumelle, American Lung Association, Washington DC, USA
Dr G Elzinga, National Institute of Public Health and Environmental Protection, Netherlands (Chair, TB/HIV Working Group)
Dr S England, Stop TB Partnership Secretariat, Switzerland
Dr M Espinal, Executive Secretary, Stop TB Partnership Secretariat, Switzerland
Dr A Kutwa, National Tuberculosis and Leprosy Programme, Kenya
Dr D Maher, Stop TB Department, World Health Organization, Switzerland
Dr PR Narayanan, Tuberculosis Research Centre, Chennai, India
Professor F Omaswa, Ministry of Health, Uganda
Dr M Raviglione, Stop TB Department, World Health Organization, Switzerland (Chair, DOTS Expansion Working Group)
Dr A Robb, United Kingdom Department for International Development
Dr K Shah, National Tuberculosis Programme, Pakistan
Dr R Tapia, National Tuberculosis Programme, Mexico
Dr K Vink, Estonia (Chair, DOTS-Plus Working Group)
Ms D Weil, World Bank, Washington DC, USA
Professor D Young, Imperial College, London, UK

ANNEX Q: LIST OF REPORT RECOMMENDATIONS

Independent external evaluation of the Stop TB Partnership: Recommendations

1. Progress in reaching the Partnership's targets has been extremely mixed, with only 16 countries having achieved the global targets. Much more will need to be done in actual implementation in the countries affected, including those not considered high burden countries, if the targets for 2005 are to be reached.
2. Internationally, significant progress has been made in engaging the corporate sector in the fight against TB. This relationship now needs to be expanded and institutionalised in the Coordinating Board and Working Groups.
3. At country level more intensive action is needed to improve only modest gains in recruiting the private for profit and non-formal health sectors into the national TB control programmes
4. In countries, the focus to date has mainly been on developing partnerships at national level. In future the emphasis will need to shift towards regional and sub-national levels and to supporting operational activities.
5. The heart of the Partnership lies in the long-term commitment of individual partners of all kinds to work in concert to achieve the agreed goals. Interviewees overwhelmingly made clear to the evaluation team their continuing deep-rooted support for the Partnership. While this is certainly sincere, it does need to be fully realised in terms of active participation (e.g. in the Partners' Forum) and resource mobilisation.
6. The Partnership should play an active role in looking at the overall sustainability issues at country level raised by the various global health initiatives collectively, and in developing concerted approaches to country-based strategies for alleviating system-wide barriers to improved health services.
7. Broad approaches to improving the management of the Global Drug Facility include:
 - a. improving the information base upon which decisions can be made
 - b. implementation of more realistic planning approaches, including a plan to address the current short to medium-term financial problems
 - c. actions to limit liabilities and maximise income with appropriate communications strategies.

Specific recommendations are set out below.

8. The GDF should establish a regular reporting system which identifies (a) when obligations are likely to fall due and (b) if, or when, the Partnership might be unable to meet its GDF commitments. This analysis needs to clearly spell out when and how much additional funding is required, when new procurement contracts (or extensions of the existing one) will need to be signed and when orders need to be placed and deliveries made if stock outs at the country level are to be avoided.
9. During the course of the evaluation, the Secretariat has prepared a revised financial statement which clearly spells out the financing requirements to meet existing commitments. It is understood that CIDA has signalled its intention to cover these funding gaps and its wish for Technical Review Committees to be resumed. The financial report should be updated and recommendations put to the Board.
10. The evaluation recommended to the Board in October 2003 that, as recommended by McKinsey, a Board Task Force should be charged to take immediate action to raise new resources to enable existing DOTS expansion commitments made through the GDF to be met. The Board has since established a Proto-Resource Mobilisation Task Force.
11. These actions should be complemented by:

- a. a strengthened communications strategy, aimed at existing and potential donors, challenging misconceptions about access to GFATM resources, and outlining possible repercussions of a failure of the Partnership to fund its GDF commitments.
 - b. Board agreement that approval of new DOTS expansion projects under the GDF grant facility should not be considered unless there is a reasonable likelihood that the requisite funds can be secured.
12. The GDF's Strategic Plan targets need to be reappraised and reflect more realistic assumptions about resource flows and other factors which may have changed since the Plan was approved.
13. The evaluation recommended in October that funding principles or guidelines to prevent excessive exposure in the medium term and a financial plan to comply with such principles should be developed. An initial draft has been prepared by the Secretariat. Once agreed, it will be important to consider what implications these guidelines have for the size of future TRC approvals and to reflect this in communication strategies.
14. Future financial statements on the GDF provided to the Board should include a detailed presentation of the medium term cash flow situation until the position has stabilised and should also monitor progress against any agreed principles or guidelines as set by the Board.
15. The GDF should strengthen the empirical base on which it makes its arguments for accessing GFATM resources.
16. The Stop TB Partnership could give guidance to the LFAs on criteria for assessing procurement plans for TB drugs.
17. Increasing the share of GFATM resources for TB is more likely to be achieved by actions at country level, aimed at CCMs, to push for inclusion of TB in GFATM proposals rather than trying to persuade GFATM to earmark specific amounts to TB. Notwithstanding this, relevant Board members might usefully try to hold the GFATM accountable to its principle of "operat(ing) in a balanced manner in terms of different regions, diseases and interventions" especially as the share of GFATM funds allocated to TB has declined during successive rounds.
18. The report recommends a five-year cycle of planning, budgeting and reporting with a mid-term review of the Global Plan and an evaluation towards the end of the cycle to provide the platform for the next five-year Global Plan. Both the outcome of the mid-term review and the next cycle's draft Global Plan should be put to the Partners' Forum for endorsement, in line with practice to date. This suggests two Partners' Forum meetings in each five-year cycle. The Basic Framework should be amended to allow the Partners' Forum to meet at least once every three years rather than every two years.
19. Each member of the Coordinating Board should take responsibility for mobilising participation in the Forum at the appropriate levels within their respective constituencies.
20. The forthcoming Partners' Forum should be used to explore mechanisms for making the various constituencies more operational.
21. A late session at the Partners' Forum in March 2004 could provide opportunity for participants to review the effectiveness of the gathering, lessons learned for the future and possible alternatives or additions, e.g. regional mini-partners' fora, piggybacking on WHO Regional Committee meetings.
22. The question of the extent to which the Coordinating Board has a steering and/or coordinating function among Partnership constituencies and components is a sensitive issue to be handled with care, but the Board should now address it in plenary.
23. The evaluation team recognises the divided views on this matter. Its recommendation to the Board is that the Basic Framework be amended to include as Board functions "to guide and provide oversight of the implementation of agreed policies, plans and activities of the Partnership; and to ensure coordination among partnership components".

24. The Board's exercise of these functions should be conducted with an emphasis on influence and consensus-seeking appropriate to a partnership of this nature. It will be appropriately conscious of the technical expertise of the Working Groups and other relevant technical bodies.
25. The relationship between the Partners' Forum and the Board should be more explicitly defined. The evaluation team sees no reason to amend the functions of the Partners' Forum which envisage the Forum providing recommendations to the Board on progress towards implementation of the Partnership. It should be explicit that strategic and operational decision-making rests formally with the Board.
26. The Board needs to address more aggressively its substantive function to mobilise adequate resources for the various activities of the Stop TB Partnership.
27. Advocacy by the Partnership should include advocacy for research activities, from basic research to operations research. The Board should ensure some contribution to the cost of New Tools Working Groups' partnership activities through the budget of the Partnership Secretariat.
28. The current composition of the Board in the Basic Framework should be amended to accommodate representation from people with TB or TB/HIV, the corporate sector, the foundations separately from financial donors, and the GFATM formally. All except the GFATM seat should rotate, with a maximum of two terms.
29. To avoid increasing commensurately an already sizeable Board, the number of seats for regional representatives should be reduced from six to three, rotating through all six regions.
30. Given four dedicated seats for high-burden countries, preference for regional seats should be given to appropriately qualified individuals from non-high burden countries.
31. WHO and the World Bank should have permanent seats but the third member for international agencies with a health mandate should be elected by the constituency rather than designated for UNICEF. WHO should take responsibility for supporting an active constituency.
32. While the Chair of the Board will want to brief all new Board members, the outgoing Board member should take responsibility for a seamless handover to his or her successor.
33. The public Stop TB website should carry a simple table of current Coordinating Board members and terms of office.
34. The processes to select Board members for rotating Board seats should be timely, transparent, fair and open. The criteria for selection should be explicit. Processes will need to be tailored to the needs of the individual constituency but should ideally include Stop TB website publication of an invitation notice with full details.
35. To refresh the Board, a working assumption of rotation after the first three year term is advisable.
36. Before each round of rotations, the Board should agree an overall assessment of the ideal balance of diversity and expertise being sought, including broader skills in, for example, advocacy or financial management.
37. In making new appointments, the Board/constituency should positively seek a balance of new blood.
38. With the transition to sustainable operations, the Board should consider and determine options for strengthening Board oversight mechanisms, streamlining Board consideration of issues through pre-processing by Board members, and delegating authority for decision-making on routine matters within agreed limits.
39. To handle these functions, the evaluation team recommends the establishment of a Executive Committee of the Board with defined delegated authority for decision-making.

- The Executive Committee should be composed of seven Board members, with a quorum of five needed to take decisions. The current Working Committee would be dissolved.
40. After appointing the members of the Committee, the Board should elect the Chair of the Executive Committee for a fixed term of two years renewable.
 41. If the Board accepts the recommendation for an Executive Committee, it should establish an ad hoc Board Task Force to develop proposals for the extent of the Executive Committee's and Executive Secretary's delegated powers, to be considered at the Board's meeting in Spring 2004. It is critical that Board members have ownership of this process.
 42. Working Groups should be limited to the term of each 5-year Global Plan with an automatic sun-setting clause, subject to review of relevance and efficacy for the next Global Plan.
 43. The positions of Working Group Chair and Secretary should not be held simultaneously by people from the same institution.
 44. A comprehensive and cohesive vision of how the various Working Group streams of activity come together is urgently required.
 45. The evaluation team endorses the recommendations from his project presented by Dr Hopewell to the October 2003 Board meeting, in particular that:
 - a. the potential contributions of new tools and approaches should be incorporated into descriptions of overall strategies to meet global targets. Where feasible, estimates of their impact should be included in disease trends.
 - b. Progress towards reaching targets for development of new tools should be included in annual Partnership reports.
 - c. There should be an annual meeting of the Chairs and focal points of all six Working Groups.
 46. These activities should be supported by the Secretariat. A full-time position to provide support and facilitation to the Working Groups is just being established.
 47. Core Partnership activities requiring active and continuing Board engagement and oversight should be eligible to be Working Groups, regardless of whether their functions are cross-cutting.
 48. Task Forces should be used for ad hoc tasks or activities which do not require direct and continuous Board engagement.
 49. The Terms of Reference for all Task Forces should set clear time-limits for the life of the body. Any long-running Task Forces should, like Working Groups, be limited to the term of each 5-year Global Plan with an automatic sun-setting clause, subject to review of relevance and efficacy for the next Plan.
 50. Appointment of members to Task Forces should be transparent and fair.
 51. Task Forces should be accountable to the Coordinating Board.
 52. Advocacy, communications and social mobilisation need a higher profile and more effective handling within the Partnership.
 53. The evaluation endorses the recommendation of the 2nd Ad Hoc Committee that global level structures must be strengthened and formalised.
 54. Specifically the Advocacy and Communications Task Force should be reconstituted as a formal Working Group of the Stop TB Partnership with representation on the Coordinating Board in the person of its Chair. Given the Board's function to coordinate and promote advocacy, the Terms of Reference of this Working Group should specify that it reports to the Coordinating Board.
 55. The Working Group should develop a more detailed plan for advocacy and communications. It should identify areas of need and potential collaboration with active global partners specialising in communications and advocacy, like the Johns Hopkins

- University's Health Communications Partnership (JHU-CCP), the Rockefeller Communication for Social Change Consortium, the Massive Effort Campaign, Results and Tb Alert. Greater involvement in this area from other more technical orientated agencies such as CDC, KNCV and the IUATLD should be encouraged.
56. The ideas on developing and expanding partnerships especially involving NGOs and civil society as set out in the draft Stop TB/WHO document "The Power of Partnerships" should be explored at regional and country level.
 57. The Secretariat's functions are broadly appropriate, subject to incorporating in the Basic Framework definition a greater emphasis on resource mobilisation, advocacy and communications, and on accountability mechanisms. The development of strategies for resource mobilisation, advocacy and communication must be underpinned by a clear delineation of the respective roles and responsibilities of the Board, of any relevant Working Group or Task Force and of the Secretariat.
 58. The function specified in the Basic Framework in relation to coordination should be clarified. An alternative wording of the function might be "to support the Board in coordinating and monitoring activities of Partnership bodies, in pursuit of Partnership targets".
 59. Board members look to the Secretariat to play an activist role in shaping strategies, securing consensus and implementing initiatives. The scope for any greater delegation of formal authority should be considered by the Board in the context of considering delegation of authority to an Executive Committee.
 60. The evaluation endorses the Board's decision that the GDF, which is managed in tandem with the Green Light Committee, should continue to function as part of the Partnership Secretariat and to report to the Executive Secretary. Filling the vacant GDF manager position with a suitably experienced candidate is an immediate priority.
 61. The location of the Secretariat in WHO benefits both parties, despite the administrative frustrations encountered. Technical relationships are strong, without compromising the Partnership's independence. WHO has played a relatively hands-off and constructive role in governance. Preliminary analysis suggests that its Programme Support Charge broadly offsets indirect costs incurred in hosting the Secretariat and that WHO makes a substantial net contribution to the Partnership. However outstanding legal and administrative difficulties now need to be resolved, including signing of a general MOU between the Partnership and WHO to reinforce provisions in the Basic Framework, and a renewal of the specific MOU for the GDF if separate MOUs are required.
 62. The innovative process used recently to appoint a new Partnership Executive Secretary could be a model for other Partnerships housed in WHO.
 63. Ideally the Executive Secretary of the Stop TB Partnership should report to the Chair of the Partnership's Coordinating Board as representative of the whole Board. However, on current WHO advice, the Executive Secretary of the Stop TB Partnership must, under the guidance of the Stop TB Coordinating Board, report formally to the WHO Director of Stop TB, so long as s/he is a WHO employee. This position should be reconsidered if a different outcome is adopted in relation to the RBM Executive Secretary since the posts are directly analogous.
 64. There should be an early review of the grading of the post of Stop TB Partnership Executive Secretary, with a view to upgrading to D1 as a minimum (or D2 if that is the grading confirmed for the post of RBM Executive Secretary with its broadly analogous responsibilities).
 65. Staff in the Secretariat are deeply committed to the mission to Stop TB. After a difficult period involving loss of key staff and serious funding challenges, the Secretariat urgently needs clear and effective leadership, a more strategic approach, stronger management and decision-taking, and better internal communications. These are key issues to be addressed by the new Executive Secretary, in close cooperation with the Board.

66. The summary picture of Secretariat human resources is that staff numbers may be a little too high, grades too low, contracts too uncertain and turnover too rapid. A comprehensive human resources strategy for the Secretariat should be developed as a matter of urgency, in concert with WHO's HRS and the MSU. It should address forecast staffing requirements, taking account of numbers, experience and skillsets, and succession planning; staffing structure; action to reduce exceptionally high turnover rates (35% over the last 12 months); and appraisal and development.
67. The GDF's staffing needs will depend on the Board's forthcoming strategic decisions on the future of the GDF. Detailed discussions with the Executive Secretary suggest there is some limited scope for staff savings (say, three positions) in the rest of the Secretariat.
68. There is urgent need to shift the balance away from so great a reliance on temporary staff and to fill more positions with fixed term staff to provide a central core for the Secretariat. This is critical at team leader level, but selected fixed term appointments at all grades, including secretaries, are important to the efficient and effective conduct of business.
69. To free more of the Executive Secretary's attention for his external functions, he should be supported by a strong management structure within the Secretariat. The obvious immediate option would be three team leaders for Partnership/Support and Innovations, the GDF and Advocacy and Communications, plus a new senior Finance and Administration Officer position to ensure the effective management of financial and human resources across the Secretariat (including the GDF).
70. The Secretariat is relatively strong on technical TB skills but there is need to develop a more managerial culture and strengthen expertise in advocacy and communications, resource mobilisation and planning/performance management.
71. Some critical issues in the HR strategy will require agreement with the MSU or WHO's central HRS. The Stop TB Partnership and its MSU need to adopt a similar approach as in the Polio Eradication Initiative, working together to find ways to reduce delays and negotiate flexibilities for core Secretariat staff.
72. Accepting the need for due process, WHO should take urgent steps to reduce the unjustifiable delay in processing fixed-term recruitments – not just for the Partnership Secretariat but for the whole of HQ. Equally, the Stop TB Partnership Secretariat need to ensure that systems are in place to ensure that the relevant paper work and applications are entered into the system and followed up.
73. The Board should agree and make available on the partnership website a full set of processes for the election of Board officers. This report makes detailed recommendations for the election of the Chair and the Vice-Chair, drawing on the experience of selecting a Chair in October 2003.
74. The Basic Framework should be amended to specify that the Vice-Chair should be elected to serve a two-year term, rather than for each session. No individual should serve more than two consecutive terms.
75. The Basic Framework should be amended to specify voting on a one member, one vote basis as a last resort, if consensus proves unachievable.
76. The Basic Framework should be amended to make explicit that each of the recognised constituencies may raise issues for consideration by the Board, either through the Secretariat or through their representative on the Board.
77. For each substantive Board meeting item, Board members should be provided with a concise paper giving key facts (including resource implications if relevant), issues, options and, wherever appropriate, recommendations.
78. The Board has already agreed at its October meeting that the first page of Board papers should highlight a brief précis of the issues, the recommendations and the action required of the Board.
79. Board members should receive all Board papers at least ten days before the meeting.

80. The Board has already accepted the evaluation team's recommendation that all Coordinating Board papers and agreed reports of meetings and teleconferences should be accessible to partners and the general public on the open website, apart from coverage of exceptional confidential issues, e.g. relating to commercial/contractual or personnel issues.
81. The Secretariat should provide a brief written progress report on past Board decisions for each Board meeting.
82. All substantive Partnership meetings should be documented and the notes made available on the website.
83. Without being drowned in detail, the Board needs more disaggregated information on what money is being spent on and how this relates to the Partnership's key objectives and outputs. A recommended reporting format is annexed to the report (Annex N).
84. Alongside a fund-raising budget, the Board should approve a realistic operational control budget for the Secretariat (including the GDF) which would provide the basis for activity implementation and for expenditure monitoring and accountability. In the event of significant changes of circumstances mid-budget, Board approval to a revision should be sought.
85. The 2004/5 plan needs to set out proposed funding sources, both to ensure its realism and to ensure that the plan is not fragmented through the use of parallel funding mechanisms such as the Trust Fund.
86. Financial reports should be amended to provide a more detailed outline of Secretariat spending based on AMS classifications, and incorporating all sources of funding.
87. The next Global Plan should set out best estimates of projected financial needs but, within this, should introduce a rolling budget process in which the budget is agreed only for the first year with a process outlined for setting budgets in subsequent years.
88. The Secretariat should strive towards producing a common performance management report for the Board and all donors which could be made available publicly, including on the website. This should provide information on expenditures and trends in progress against an agreed set of performance indicators over time against targets.
89. The Board should receive at each meeting a specific summary report on the performance of the GDF (no more than two pages : format at Annex K).
90. A more detailed GDF monitoring report for internal management purposes should be introduced (Annex L).
91. The Board should produce an annual report for the Partnership which would provide key performance management highlights along with effective advocacy material. Members may wish to form an ad hoc task force to identify the key contents of such a report.
92. The Board should develop a formal results-based management approach to monitoring progress against the Global Plan, with a mid-term review and end evaluation for each five-year cycle. In particular, it should seek the agreement of the Working Groups to annual financial and activity reporting on the understanding that the reports will be used effectively to assess collective progress towards targets.
93. The Partnership should contract out a survey of global flows of funding for TB to feed into the next Global Plan. On the basis of that experience, the Board should consider introducing periodic monitoring of global funding flows, working in liaison with WHO to feed into subsequent mid term reviews and global plans. Particular emphasis should be placed on an analysis of existing GFATM grants.