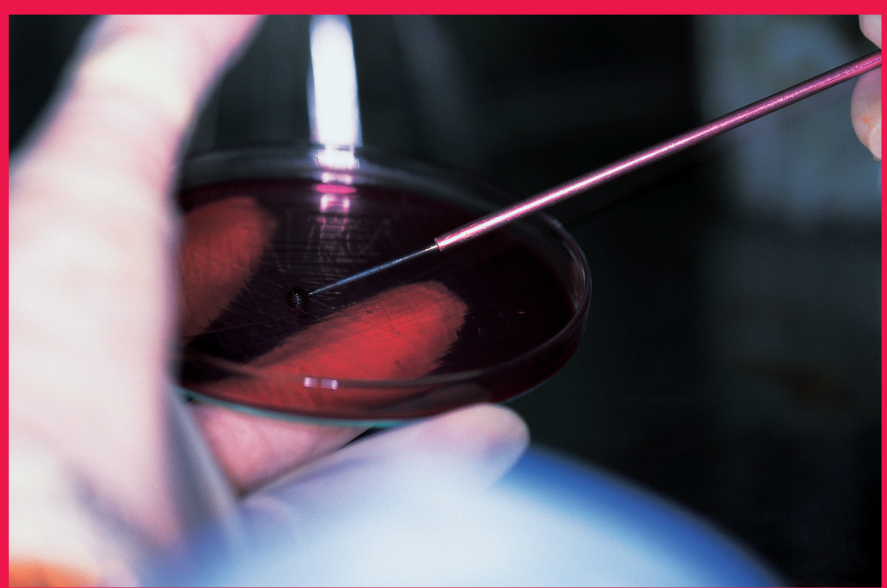
GPR

THE STOP TUBERCULOSIS PARTNERSHIP



IEG
INDEPENDENT EVALUATION GROUP

GLOBAL PROGRAM REVIEW

Volume 4 Issue 1

THE WORLD BANK GROUP

WORKING FOR A WORLD FREE OF POVERTY

The World Bank Group consists of five institutions—the International Bank for Reconstruction and Development (IBRD), the International Finance Corporation (IFC), the International Development Association (IDA), the Multilateral Investment Guarantee Agency (MIGA), and the International Centre for the Settlement of Investment Disputes (ICSID). Its mission is to fight poverty for lasting results and to help people help themselves and their environment by providing resources, sharing knowledge, building capacity, and forging partnerships in the public and private sectors.

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The Stop Tuberculosis Partnership

November 19, 2009
Corporate and Global Evaluations and Methods

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This volume is a product of the staff of the Independent Evaluation Group (IEG) of the World Bank Group. It is part of an ongoing series that reviews global and regional partnership programs in which the World Bank is engaged as one of the partners. The findings, interpretations, and conclusions expressed in this volume do not necessarily reflect the views of the Executive Directors of The World Bank or the governments they represent.

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Cover image: Instituto Pedro Kouri (IPK), Havana: TB vaccine research. A technician inoculating a media plate with TB mycobacteria that have had their DNA transformed. As part of vaccine research, the recombinant strains will express the required antigens. Photo by Andy Crump. © WHO/TDR/Crump.

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IEG Mission: Improving Development Results Through Excellence in Evaluation

The Independent Evaluation Group (IEG) of the World Bank reviews global and regional partnership programs (GRPPs) in which the Bank is engaged as one partner among many for two main purposes: (a) to provide accountability in the achievement of the program's objectives by providing an independent opinion of the program's effectiveness, and (b) to identify and disseminate lessons learned from the experience of individual GRPPs. The preparation of a global or regional program review (GPR) is contingent on a recently completed evaluation of the program, typically commissioned by the governing body of the program.

The first purpose above includes validating the findings of the GRPP evaluation with respect to the effectiveness of the program, and assessing the Bank's performance as a partner in the program. The second purpose includes assessing the independence and quality of the GRPP evaluation itself and drawing implications for the Bank's continued involvement in the program. Assessing the quality of GRPP evaluations is an important aspect of GPRs, since encouraging high quality evaluation methodology and practice more uniformly across Bank-supported GRPPs is one of the reasons why IEG embarked on this new product in 2005.

IEG annually reviews a number of GRPPs in which the Bank is a partner. In selecting programs for review, preference is given to those that are innovative, large, or complex; those that are relevant to upcoming sector studies; those for which the Executive Directors or Bank management have requested reviews; and those that are likely to generate important lessons. IEG also aims for a representative distribution of GPRs across sectors in each fiscal year.

A GPR is a "review" and not a full-fledged "evaluation." It assesses the independence and quality of the relevant evaluation; provides a second opinion on the effectiveness of the program; assesses the performance of the Bank as a partner in the program; and draws lessons for the Bank's engagement in global and regional programs. The GPR does not formally rate the various attributes of the program.

A GPR involves a desk review of key documents, consultations with key stakeholders, and a mission to the program management unit (secretariat) of the program if this is located outside the World Bank or Washington, DC. Key stakeholders include the Bank's representative on the governing body of the program, the Bank's task team leader (if separate from the Bank's representative), the program chair, the head of the secretariat, other program partners (at the governance and implementing levels), and other Bank operational staff involved with the program. The writer of a GPR may also consult with the person(s) who conducted the evaluation of the GRPP.

Each GPR is subject to internal IEG peer review, Panel review, and management approval. Once cleared internally, the GPR is reviewed by the responsible Bank department and the secretariat of the program. Comments received are taken into account in finalizing the document, and the formal management response from the program is attached as an annex to the final report. After the document has been distributed to the Bank's Board of Executive Directors, it is disclosed to the public on IEG's external Web site.

Abbreviations and Acronyms

ACSM	Advocacy, communication and social mobilization
AIDS	Acquired Immunodeficiency Syndrome
AFRO	WHO Regional Office for Africa
ARV	Antiretroviral treatment
CDC	Centers for Disease Control
CDR	Case detection rate (i.e., smear-positive case detection rate,)
CIDA	Canadian International Development Agency
DALY	Disability-adjusted life year (a measure of the burden of disease and injury)
DDR	DOTS detection rate (i.e., smear-positive case detection rate under DOTS)
DFID	Department for International Development (United Kingdom)
DGF	Development Grant Facility (World Bank)
DOTS	Directly Observed Treatment Short-Course, the basic package that underpins the Stop TB Strategy
DP	Direct Procurement
FIND	Foundation for Innovative New Diagnostics
GATB	Global Alliance for TB Drug Development
GAVI	Global Alliance for Vaccines and Immunization
GDEP	Global DOTS Expansion Plan
GDF	Global Drug Facility
GLC	Green Light Committee
GPSTB	Global Plan to Stop TB
GTRI	Global TB Research Initiative
HBC	High Burden Country
HIV/AIDS	Human immunodeficiency virus/Aids
HNP	Health, nutrition and population sector (World Bank)
IAVI	International AIDS Vaccine Initiative
IEDC	Infectious and Endemic Disease Control Project (China)
IEG	Independent Evaluation Group (World Bank)
IUATLD	International Union Against Tuberculosis and Lung Disease (The Union)
KNCV	Royal Netherlands Tuberculosis Association
MDR-TB	Multidrug-Resistant Tuberculosis
MDGs	Millennium Development Goals
MoH	Ministry of Health
MSF	Médecins Sans Frontières (Doctors without Borders)
n/a	Not applicable (or not available, according to context)
nd	No date
NGO	Non-Governmental Organization
NTP	National Tuberculosis Control Program or equivalent
PAHO	Pan-American Health Organization
PQ	Prequalification (of drugs for international procurement and financing)
PTB	Pulmonary Tuberculosis
SCC	Short-course chemotherapy
SWAP	Sector Wide Approach (a methodology for donor coordination around a country's sector program)
TB	Tuberculosis
TB CAP	Tuberculosis Control Assistance Program
TBCTA	TB Coalition for Technical Assistance
TBDI	TB Diagnostic Initiative
TBL	Tuberculosis and Leprosy
TBP	Stop TB Partnership
TBTEAM	TB Technical Assistance Mechanism

TDR	Special Programme for Research and Training in Tropical Diseases
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
The Union	International Union Against Tuberculosis and Lung Disease
UNITAID	International facility for the purchase of drugs to treat HIV/AIDS, malaria, and TB
USAID	United States Agency for International Development
WG	Working Group
WHO	World Health Organization
WHO-STAG	WHO Strategic and Advisory Group for Tuberculosis
WTBD	World TB Day (24 March)
XDR-TB	TB due to MDR strains that are also resistant to a fluoroquinolone and at least one second-line injectable agent (amikacin, kanamycin and/or capreomycin)

Fiscal Year of Program

January 1 – December 31

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Program at a Glance: Stop TB Partnership

Start Date	1998 (Stop TB Initiative), 2001 (Stop TB Partnership formally launched)
Mission/Goal	To eliminate tuberculosis as a public health problem, and, ultimately, to obtain a world free of TB.
Objectives	1. Expand the DOTS strategy so that all people have access to effective diagnosis and treatment • Accelerate implementation to provide for at least 70 percent infectious case detection, and maintain a treatment success rate of at least 85 percent • Improve procurement and distribution systems for TB drugs to ensure quality, access and timely supply • Implement monitoring and evaluation systems for national TB programs in line with WHO standards 2. Develop and scale-up effective responses to the emerging challenges of drug resistance and HIV-related TB 3. Improve and expand tools available for TB diagnosis, treatment and prevention • Accelerate basic and operational research for the development of new diagnostics, drugs and vaccines • Promote adoption of new and improved tools by ensuring appropriate use, access and affordability 4. Strengthen the overall global partnership to Stop TB so that proven TB-control strategies are effectively applied: • Develop the Global Plan to Stop TB for the period 2006–2015 (initially to 2010) • Promote the development of national and international partnerships to stop TB with all stakeholders in society
Major Activities	• Three Partners' Forums organized to galvanize Partners (Governments, International Organizations, NGOs, Specialized TB Advocacy and Research Institutions, patient groups — presently over 900 partners) to adopt/promote a cohesive tuberculosis prevention and control strategy based on DOTS • Governance structure established, including six working groups to address priority areas including DOTS expansion, MDR, TB/HIV, New Drugs and Vaccine development Working Group • Global Drug Facility established to provide free and affordable anti-TB drugs, as well as quality-assurance and technical assistance, to countries through grant-making and Direct Procurement of drugs and diagnostics; procurement of second-line anti-TB drugs. • Technical and policy support to WHO and its members to prevent the spread of Multi Drug Resistance through the Green Light Committee • Research and development for new TB drugs, diagnostics, and vaccines being systematically promoted • Global Plans developed • Inclusion of TB as the third disease in the Global Fund achieved and cooperation established • Series of World Health Assembly (WHA) resolutions initiated and supported which anchor Stop TB objectives and operational targets as international obligations
World Bank Contributions	Instrumental in launching program, staff support in conducting all Partners' Forums; annual DGF grant of US$700,000 since Partnership inception. Collateral support through project investment lending in high-burden countries in Asia, Eastern Europe and Latin America Permanent member of Coordinating Board

Other Donor Contributions	Consistent major donors and collaborators from the Partnership's inception include USAID, CDC, Netherlands, DFID, CIDA; others have since joined as donors/collaborators
Location	Stop TB Secretariat is housed at WHO headquarters, Geneva, adjacent to WHO Stop TB Department
Web site	www.stoptb.org
Governance and Management	Four distinct entities comprise the Stop TB Partnership: the Partners' Forum, Coordinating Board, Working Groups, and Secretariat. • **Partners' Forum**: the formal assembly of the Stop TB Partnership; works to increase collaboration among Partners, focus commitment on achievement of the Partnership's objectives, track the Partnership's progress, and serve as an open forum for information exchange. • **Coordinating Board**: provides leadership in monitoring and directing the implementation of the Partnership's policies, plans and activities, and plays a central role in the coordination of Partnership bodies; prioritizes areas for action and supports the Partnership in achieving its established aims through resource mobilization; oversees and reviews the Secretariat work plan, budget and implementation; adopts financial policy to guide Secretariat action; coordinates advocacy activities; establishes committees, working groups, and task forces as necessary; and represents the Stop TB Partnership in external forums. • **Working Groups:** undertake research, advocacy, and/or operational functions in promotion of the Partnership's overall goals (DOTS Expansion Working Group, TB-HIV Working Group, Stop TB Working Group on MDR-TB, Working Group on New TB Drugs, Working Group on New TB Diagnostics, Working Group on New TB Vaccines); collaborate with other areas of the Partnership to improve coordination and add value to Partnership activities, and play a central role in advocacy and building consensus and commitment. (Recently, the Advocacy and Social Mobilization Working Group was disbanded, and a Global Laboratory Initiative and sub-group on infection control were created.) • **Secretariat**: housed at WHO in Geneva; provides administrative, operational, and strategic support to the Partnership; is accountable to the Coordinating Board. • **Global Drug Facility** provides anti-TB drugs, quality-assurance and technical assistance, to countries through grant-making and Direct Procurement of drugs and diagnostics. Procures second-line anti-TB drugs. • **Green Light Committee** provides technical and policy support to WHO and its members to prevent the spread of Multi Drug Resistance (WHO administers GLC Secretariat).
Latest Program-Level Evaluation	McKinsey & Company; Independent External Evaluation of the Stop TB Partnership; April 21, 2008, covering the period from the Partnership's inception in 2001 to 2006.

Key Bank Staff Responsible during Period under Review

Position	Person	Period
Global Program Task Team Leader	Jacques Baudouy Olusoji Adeyi Montserrat Meiro-Lorenzo	2001–2005 2005–2009 2009–present
Director, Health, Nutrition and Population Sector	Richard Feachem Christopher Lovelace Jacques Baudouy Cristian Baeza (Acting) Julian Schweitzer	1995–1999 1999–2002 2003–2007 2007 2007–present
Vice President, Human Development Network	David de Ferranti Eduardo Doryan Jozef Ritzen Jean-Lous Sarbib Joy Phumaphi	1996–1999 1999–2001 2001–2003 2003–2006 2007–present
Director, Global Partnership and Trust Fund Operations	Margaret Thalwitz Junhui Wu	May 2004–2008 March 2008–present

Program Manager

Position	Person	Period
Executive Secretary, Stop TB Partnership	Dr. Jacob Kumaresan Dr. Marcos Espinal	2001–2003 2003–present

Glossary of Technical Terms

DOTS-Plus	The adaptation of DOTS to respond to multidrug-resistant TB.
Extrapulmonary TB	TB affecting a part of the body other than the lungs.
Generic drugs	Non-proprietary pharmaceutical products.
Global Drug Facility	A mechanism (facility) established as an initiative of the Stop TB Partnership to expand access to, and availability of high-quality TB drugs to facilitate global DOTS expansion.
Green Light Committee	A committee established by the Stop TB Partnership which provides technical policy and procedural support for drug-resistant TB to WHO and its members. It facilitates procurement of quality controlled affordable second-line anti-TB drugs.
High burden countries (HBCs)	The 22 countries accounting for approximately 80 percent of all new TB cases arising each year.
HIV-related TB	TB occurring in somebody infected with HIV.
HIV status	The state of being HIV-positive or HIV-negative.
Incidence	The number of new cases of a disease arising in a given period in a specified population.
International Standards for TB Care	A widely accepted level of care that all practitioners should follow in dealing with patients with TB or with symptoms and signs suggestive of TB.
Latent TB infection	The presence in the body of tuberculosis bacilli that are dormant (usually in the lung) and not causing harm, but that may become active and cause disease.
Multidrug-resistant TB	TB infection which is resistant to treatment by isoniazid and rifampicin (the two most effective anti-TB drugs).
Prequalification of manufacturers or suppliers of TB Drugs	Prior approval by a competent authority — here WHO — of prospective bidders previous to the initiation of a procurement process. Prequalification is based upon the capability and resources of prospective bidders to perform the particular contract satisfactorily. Prequalification includes certification by WHO following a “good manufacturing processes” (GMP) inspection.
Prevalence	The number of cases of a disease in a defined population at a specified point of time.
Pulmonary TB	TB affecting the lungs.
Sputum smear-negative	Absence of TB bacilli on sputum microscopy.
Sputum smear-positive	Presence of TB bacilli on sputum microscopy.
Stop TB Strategy	The new WHO-endorsed strategy for TB control elaborated and adopted by Stop TB in 2006 that encompasses and goes beyond the DOTS strategy.

Preface

The Stop TB Partnership is a network of international organizations, countries, governmental and nongovernmental organizations, public and private sector donors, and individuals dedicated to the elimination of tuberculosis as a public health problem. The Partnership is a loose coalition of partners working to elevate action on tuberculosis, one of the leading causes of death from infectious disease, on the global agenda.

The Stop TB Partnership was formally established in 2001, as it became clear to the international community that the initial targets set for TB control in 1991 by Resolution WHA44.8 would not be met by following the DOTS strategy alone (WHO's five-point policy package for TB control) and that greater collaboration among international agencies, donors, and governments of endemic countries on an adjusted TB control strategy and timeframe would be necessary. Following the Ministerial Conference on TB and Sustainable Development in Amsterdam in March 2000, the first Stop TB Partners' Forum in Washington, DC, in March 2001 approved the formal structure of the Stop TB Partnership and officially launched the Global Plan to Stop TB for 2001–05. The first meeting of the Stop TB Coordinating Board was held in the same year in Annapolis, Maryland. The Second Partners' Forum was held in New Delhi in March 2004 and the third Partners' Forum in Rio de Janeiro in March 2009.

In 2007, the Coordinating Board of the Stop TB Partnership commissioned an external evaluation — covering the period 2001–2006 — to assess the Partnership's performance in the areas of governance, management, interactions with the TB community and beyond, and its overall effectiveness at promoting TB control at the country level. WHO, on behalf of the Partnership, issued a Request for Proposals in March 2007, and the evaluation was completed by McKinsey & Company in April 2008.

This Global Program Review (GPR) assesses the quality and independence of the 2008 evaluation of the Stop TB Partnership; provides a second opinion on the effectiveness of Stop TB's work; assesses the performance of the Bank as a Partner of Stop TB; and draws lessons for the future of the Partnership. It covers the period from the Partnership's inception in 2001 to the present.

The Review follows IEG's Guidelines for Global Program Reviews (Annex A). It is based on a desk review of relevant documents including, in addition to the 2008 evaluation, Stop TB annual reports, consultant studies, journal articles, Web sites, and interviews in Geneva and Washington with Partnership managers and staff. A mission to the Partnership Secretariat and WHO Stop TB Department in Geneva took place in January 2009. Telephone and office interviews with other stakeholders and persons knowledgeable about the Partnership, including World Bank staff, complemented interviews with Stop TB personnel in Geneva.

IEG gratefully acknowledges all those who made time for interviews, in particular Stop TB partners, management and staff. The complete list of people consulted can be found in Annex L.

Copies of the draft GPR were sent to Stop TB management, to the Bank unit which is responsible for the Bank's involvement with Stop TB (the Health, Nutrition and Population Department), and to other Bank units that have responsibility for the Bank's engagement with global programs more generally. All comments received were taken into account in finalizing this GPR. The formal response of Stop TB management can be found as Annex M.

Executive Summary

Background

1. The Stop TB Partnership is a coalition of international organizations, countries, governmental and non-governmental organizations, public and private sector donors, and individuals dedicated to the elimination of tuberculosis as a public health problem. It was formally established at the First Partners' Forum in Washington, DC, in March 2001, hosted by the World Bank, in order to foster greater collaboration among international agencies, donors, and governments of endemic countries in meeting global TB control targets. Its annual expenditures, including for the procurement of TB drugs through the Global Drug Facility, have increased from US$18.1 million in 2002 to $86.4 million in 2008.

2. The Partnership comprises four basic structures: the Partners' Forum, the Coordinating Board, several Working Groups, and the Secretariat. The Partners' Forum is the "General Assembly" which meets every 3–4 years to increase collaboration among the 900 plus Partners, to focus commitment on achievement of the Partnership's objectives, to track the Partnership's progress, and to serve as an open forum for information exchange. The constituency-based Coordinating Board (the Partnership's governing body) provides leadership and accountability in directing, coordinating and monitoring the implementation of the Partnership's policies, plans and activities.

3. Seven Working Groups for research and operational functions support the Partnership's overall goals, specifically in areas such as DOTS expansion, multi-drug resistant TB, HIV-related TB and the Global Laboratory Initiative (GLI). The Secretariat, which is housed at WHO in Geneva and accountable to the Coordinating Board, provides administrative, operational, and strategic support to the Partnership. It also manages the Global Drug Facility (which undertakes procurement of anti-TB drugs and diagnostics) and provides support to the WHO Green Light Committee (which promotes access to and rational use of second-line anti-TB drugs to prevent the spread of drug resistance).

4. The mission of Partnership has been clear from the beginning — to eliminate tuberculosis as a public health problem. The specific objectives for which the Partnership has been accountable have evolved somewhat since 2001, and have recently been stated most clearly in the Global Plan to Stop TB, 2006–2015. Since the present GPR covers the period from the initiation of the program to the present, it has reviewed the achievements of the Stop TB Partnership against four objectives which have been synthesized from core Partnership documents going back to 2001, namely: (1) to expand the DOTS strategy so that all people have access to effective diagnosis and treatment; (2) to develop and scale-up effective responses to the emerging challenges of drug resistance and HIV-related TB; (3) to improve and expand tools available for TB diagnosis, treatment and prevention; and (4) to strengthen the overall global partnership to Stop TB so that proven TB-control strategies are effectively applied. On the whole, Stop TB's objectives have stayed remarkably consistent since 2001, with mostly minor adjustments over time.

Independence and Quality of the External Evaluation

5. The external evaluation, which was completed by McKinsey & Company in April 2008, was conducted independently of the Stop TB Secretariat. The Coordinating Board commissioned and financed the evaluation from program funds. An eight-member subcommittee of the Board — the Evaluation Steering Committee — managed the bidding, selection and review process. The full text of the final report has been disclosed on the Stop TB Web site.

6. The evaluation team confronted three issues at the outset of the evaluation: (a) the lack of a set of explicit objectives for the Partnership itself; (b) the boundaries of the Partnership; and (c) a cumbersome terms of reference. Faced with these issues, the evaluation team defined the Partnership as a "set of bodies specific to the Partnership" and developed their own evaluation approach which may be characterized as a "results-based" rather than an "objectives-based" methodology, which the Evaluation Steering Committee agreed to. Given the young age of the Partnership, the team also directed a substantial focus of the evaluation on the value of the Partnership's processes.

7. The final evaluation report is a high quality report that comprehensively addresses the key aspects of the Partnership, shows where the Partnership adds value and concludes why it has made an impact. The report succinctly addresses issues of overall objectives, goals, governance and structures, and provides clear recommendations for the Partnership for the future.

MAJOR FINDINGS AND RECOMMENDATIONS

8. The 2008 evaluation concluded that the Partnership had contributed significantly to the global effort to stop TB during 2001–2006, and that it had greatly added value to what would have been achieved in terms of tuberculosis control and research in its absence. The Partnership's results were defined in five key areas: (a) expanding and strengthening the partnership of organizations involved in TB control and research; (b) broadening the agenda for, achieving consensus on, and providing guidance for TB control and research; (c) expanding the reach and impact of global TB advocacy; (d) coordinating and supporting Partners' activities in key areas; and (e) improving TB control in countries directly and indirectly.

9. The evaluation's recommendations focused more on the how, as opposed to the what, of the Partnership's work. The essence of these recommendations is as follows: (a) to invest more effort in data and analysis to identify and agree on the biggest opportunities to drive progress in TB control and research; (b) to integrate the strategies of individual Partnership bodies into a unifying Partnership strategy; (c) to concentrate Partnership efforts and resources on delivering on the big opportunities, rather than spreading these too thinly across too many issues; (d) to maximize the use of Partnership levers to influence countries, Partners, and other actors and to hold them to account for delivering on commitments; and (e) to increase performance transparency regarding the impact and efficiency of the Partnership and its bodies. Stop TB management and staff have responded positively to the major findings and recommendations of the evaluation.

The Effectiveness of the Stop TB Partnership

RELEVANCE

10. Tuberculosis is one of the leading causes of death from infectious disease worldwide, significantly contributing to poverty, straining health systems and inhibiting development. HIV-related TB is a particularly urgent issue; the relative risk of developing TB is 5–10 percent annually for HIV/AIDS patients, compared to an entire lifetime risk of 10 percent for non-HIV infected individuals. This increasing burden of TB-HIV, along with pressing diagnostic, treatment and resistance issues, requires a comprehensive tuberculosis control strategy.

11. The Stop TB Partnership's vision, mission, and targets for eliminating tuberculosis as a public health problem are fully consistent with these current global challenges and priorities in relation to TB. Partnership activities are carried out at the appropriate level — global, regional, national, and local — in terms of efficiency and responsiveness to the needs of beneficiaries. A key strength of the Partnership is that labor is appropriately distributed among partners in areas such as technical assistance.

12. The Partnership provides a range of forums for collaboration and endorses WHO's normative guidelines, but does not issue guidelines of its own. The majority of efforts have been focused on global advocacy and on filling gaps, such as in the areas of access to high-quality drugs through the Global Drug Facility and Green Light Committee. Partnership activities are not competing with or substituting for activities that individual donors or countries are doing more efficiently on their own.

EFFICACY

13. The major conclusion of the 2008 independent evaluation was that *the Partnership has had a significant impact on TB* control *and research and should set "high aspirations" for future achievements*. The present GPR finds this positive assessment of the Partnership's achievements to be justified. The Partnership has built a solid platform for expanded impact and continued progress towards achievement of its objectives.

14. The expansion of the DOTS strategy is now almost complete. A total of 187 countries now implement DOTS. The 22 High Burden Countries reported that 98 percent of the population was covered by DOTS in 2006, compared to 61 percent in 2001. Worldwide, the prevalence of TB has dropped from 262/100,000 persons in 2002 to 206/100,000 persons in 2006, and mortality from 32 to 26/100,000 persons during the same time period. But these reductions are lower than expected at the inception of the program due to the dramatic increase in HIV-related TB cases and emerging drug resistance. The overall incidence per capita appears to have stabilized or just begun to decline.

15. The Partnership established a Global Task Force on TB Impact Measurement in 2006 to report regularly on progress towards targets and to strengthen national capacity in monitoring and evaluation of TB control. Following two years of work by the Secretariat and WHO, a set of policies and recommendations for measuring incidence, prevalence and

mortality from 2008 onwards, focusing on the 2015 impact targets, have been agreed upon and are now being utilized by national programs.

16. It is now widely recognized that tuberculosis will not be successfully controlled or eliminated with the present tools. The Partnership has been successful in making this point internationally, in profiling the research agenda to donors such as the Gates Foundation, and in mobilizing "parallel" resources for development of new tools for TB control. Collateral commitments for research and development of new drugs, diagnostics and vaccines reached $1 billion in 2007, and there are now several new drugs, diagnostics and vaccines in the pipeline or in clinical trials.

17. The Partnership has significantly increased the political visibility of tuberculosis on the global scale. It has been instrumental in the inclusion of TB in the portfolio of the Global Fund to Fight AIDS, TB and Malaria as well as on the agenda of two G8 summits. Additionally, the Partnership's objectives and activities have been systematically formalized as internationally applicable through a series of World Health Assembly Resolutions.

18. The Partnership has increased its number of Partners from 40 in 2001 to over 900 presently. While this represents significant progress, it also poses the significant challenge of coordinating the efforts of such a high volume of partners. The External Evaluation recommended that Stop TB publish a full global plan progress report every three years, prior to the Partners' Forum, and focus the Forum on discussing these reports.

19. The Partnership is now widely recognized as a legitimate forum for discussion of tuberculosis control policies, strategies and technical issues, and an effective mechanism for global coordination. With a diverse range of Partners, including those with a long history of interest in TB control, and with WHO as its host organization, the Partnership has become the "glue" holding together the "community" involved in tuberculosis control.

EFFICIENCY

20. The linkages created by housing both the Partnership Secretariat and the Stop TB Department at WHO have generated a cost-effective and efficient organizational relationship that has been a key to the program's achievements as a whole. This "host" relationship has facilitated day-to-day operations, provided highly valued coordination and allowed for beneficial complementarities.

21. The administrative costs of the Stop TB Partnership Secretariat have averaged 17 percent since 2002, which includes some administrative costs for GDF operations. Channeling development assistance, particularly for drugs through the Global Drug Facility, the Stop TB Partnership has reduced transaction costs compared to traditional development assistance and also avoided interruptions in availability (stock-outs). The Partnership has also helped to harmonize donor efforts and consolidate disbursement and monitoring and evaluation.

GOVERNANCE AND MANAGEMENT

22. The Stop TB governance structure encourages collaboration and cooperation without attempting to direct or control individual partners. The Partnership provides a range of

forums for collaboration. In particular, the inclusive and consultative Partners' Forum is a highly visible platform for partner representatives to share achievements and challenges, endorse common strategies and consolidate commitment. Responsibilities, such as providing technical assistance and participating in Working Groups, are appropriately distributed among partners based on institutional expertise and intended contribution to Stop TB.

23. The Partnership's accountability mechanisms are largely appropriate. The constituency-based Coordinating Board provides leadership and direction for the Partnership and serves as an active information channel to its constituencies. The Secretariat is accountable to the Coordinating Board, with the Executive Secretary of the Stop TB Partnership Secretariat serving as Secretary of the Board. The Executive Secretary also reports to WHO on all administrative matters.

24. While overall Partnership accountability mechanisms seem generally appropriate and transparent, the 2008 evaluation found deficiencies in "performance transparency" relating to the impact and efficiency of the Working Groups. It stressed the need to systematize processes for their establishment and performance review, and recommended that Working Groups be formed for a fixed duration of 3 years, reviewed every 3 years by the Coordinating Board, and created and disbanded in response to their performance and changing areas of need.

SUSTAINABILITY

25. The sustainability of the outcomes of the Partnership's activities depends not only on the sustainability of the Partnership itself, but also on its ability to adapt to changing circumstances, on the complementary activities of its donor partners, and on the capacity of high-burden countries to sustain tuberculosis control.

26. The *Basic Framework of the Global Partnership to Stop TB* envisages that the Partnership will exist "as long as needed" to achieve its central goal of eliminating TB as a public health problem. The Partnership seeks to respond flexibly to a continually changing landscape. For instance, t*h*e Global Drug Facility was founded as a time-limited body with an expected life of 10–15 years to create a market for TB drugs with transparent and competitive procurement (which it has done), and ultimately to transfer drug procurement back to participating nations.

27. Country ownership, in terms of both financial and political commitment, is central to Partnership activities. The Partnership supports countries in sustaining tuberculosis control through technical assistance and capacity building. TBTEAM, a mechanism created by Stop TB Partners in 2007, facilitates access to high-quality, efficient technical assistance. Partners provide resources that are additional to existing national program activities and operate with an exit strategy in order to ensure that countries do not become dependent on external resource flows.

World Bank's Performance in the Partnership

28. The World Bank supports tuberculosis control on many levels. Globally, it has provided financial contributions through Window One of its DGF facility; at the country

level, it has provided financial support through lending operations. In addition, the World Bank exercised its convening power at the formative stages of the Partnership and remains a permanent member of the Coordinating Board. Until the creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria in 2002, the Bank was the largest provider of financial resources for TB control, strategically supporting tuberculosis control through financing DOTS expansion.

29. Today, the Partnership views the Bank primarily and unsurprisingly as a major source of financing for national control programs, as evidenced by an initial WHO secondment and subsequent financing of a World Bank TB specialist by the Partnership. This view is further based on the track record of major investment lending for TB in Asia, Eastern Europe and Latin America in the last two decades**.** Large investment operations in China, India and Russia are recognized as having been instrumental in establishing DOTS in these countries. However, there are few Bank-supported projects with TB components in the Bank's Africa portfolio — a gap that has not gone unnoticed by civil society groups and others.

30. A major constraint on World Bank partnership in Stop TB has been client countries' inability to use IDA funding for the procurement of anti-TB drugs through the Global Drug Facility (GDF) since the Bank has not yet deemed such procurement to be in accordance with its procurement guidelines. The resolution of this issue, which has extended over two years, has only recently been given high priority. The major issue has been the use of a procurement agent by the GDF. Other Stop TB partners have found it strange that procurement of Bank-financed anti-TB drugs must be undertaken via mechanisms other than the GDF, since they view the GDF as the best mechanism for the acquisition of low-cost and efficient quality-drug procurement for TB.

Lessons

31. The experience with the Stop TB Partnership offers a number of lessons for the Partnership and for other global health programs:

(1**)** Both a clearly "operationalized" control strategy (such as the Global Plans to Stop TB, 2001–2005 and 2006–2015) and broad consensus among partners on the technical features of that strategy have been key drivers of its achievements, since infectious disease control programs are to a large extent technology-dependent.

(2) An inclusive, collaborative approach has managed to attract and draw on the strengths of diverse constituencies involved in TB control without compromising their individual autonomy. Despite their diversity, a shared understanding of the roles, responsibilities and commitments of Stop TB Partners has allowed each to contribute in relation to their respective comparative advantages.

(3) Innovation has been an essential feature of the Stop TB approach. Important and new Partnership bodies such as the Global Drug Facility and the Green Light Committee have been created in response to pressing needs. Both are innovative mechanisms not only for TB control but also for the broader field of public health. At the same time, the Partnership has demonstrated the flexibility to "dissolve" institutional entities

such as Advocacy, Communication and Social Mobilization Working Group when no longer needed.

(4) The Partnership has built a special relationship with its host agency, WHO. The Partnership Secretariat is located within the WHO Stop TB Department and has developed an excellent working relationship with the Department. Although WHO retains an institutional mandate for the formulation of tuberculosis control norms, it benefits from extensive discussions with Stop TB Partners when issuing normative directives and technical guidance, building on consensus among member states and a wide range of partners.

(5) The Stop TB Partnership has developed and capitalized on its political "know how" to make its global efforts widely visible (G8 and the Global Fund). It has addressed both the technical issues and the socio-political forces that must inevitably be harnessed to achieve dramatic and lasting improvements in the health status of poor and marginalized segments of the population.

32. The Bank has been a major institutional player in the Stop TB Partnership. It has acquired a positive reputation among other Partners due to its effective engagement with other Partners during the creation of the Partnership and due to its country-level project work on TB control. However, when the Bank engages in a program as important as Stop TB, it is viewed by outsiders as a single institutional player and not as a "federation of Regions". Differences in approaches to development assistance across the Bank's Regions (particularly the lower level of attention to TB in the Africa lending portfolio) need to be addressed and explained at the institutional level to avoid damaging the Bank's reputation among other stakeholders.

33. Client countries' persistent inability to procure drugs with World Bank funds through the Global Drug Facility is not easily understood by external observers. Such differences between WHO-GDF and the Bank should not be allowed to remain unresolved for several years, but dealt with conclusively. The failure to resolve this issue over a protracted period of time risks reflecting negatively on the institutional reputation of the Bank.

1. Background of the Stop TB Partnership

Evolution of the Program

1.1 The Stop TB Partnership is a coalition of international organizations, countries, governmental and non-governmental organizations, public and private sector donors, and individuals dedicated to the elimination of tuberculosis as a public health problem.

1.2 The Partnership traces its roots to several initiatives launched by WHO over the past twenty years. In 1988, WHO created a "TB Unit within its Communicable Diseases Programme" to deal with the re-emergence of tuberculosis on a global scale. In 1991, World Health Assembly (WHA) Resolution No. 44.8 set an ambitious target for TB control of diagnosing 70 percent of cases and curing 85 percent of sputum-positive patients by the year 2000.[1] To achieve this goal, the Resolution encouraged the integration of tuberculosis into primary health care programs, called for increased extra-budgetary resources, and sought the participation of international, bilateral and non-governmental organizations to provide direction and coordinate activities for combating tuberculosis. In 1994, a five-point policy package for tuberculosis control, branded as DOTS (Directly Observed Treatment Short Course), was launched by WHO (Table 1). Its five components were: increased political commitment, sputum smear microscopy for diagnosis of infectious patients, standardized short course chemotherapy (SCC), secure drug supply, and a recording and reporting system. This approach was formally adopted in 1995 as WHO's official TB treatment strategy. Within a few years, however, it became clear that a majority of high-burden countries would not meet the targets originally set for 2000. This challenge was discussed by the ad-hoc committee in 1998.

Table 1. Framework for Effective Tuberculosis Control [branded as DOTS]

Objective	Core Intervention
Mobilize resources and capacity to pursue TB control within general health system development and with community involvement	Mobilization of government commitment to sustained TB control activities
Provide timely diagnosis of at least sputum-smear positive (infectious) TB patients (those most at risk of death and transmitting disease)	Case detection by sputum-smear microscopy among symptomatic patients self-reporting to health services
Provide treatment to cure at least infectious cases	Standardized treatment regimen of 6–8 months for at least all confirmed sputum smear positive cases, with proper case management, including direct observation, for at least the initial 2 months
Ensure no patient goes without medicines and reduce risk of drug resistance	A system for regular, uninterrupted supply of all essential anti-TB drugs
Track the epidemic, motivate providers and hold them accountable for their patients' care	A standardized recording and reporting system that allows assessment of individual patient treatment results, as well as overall coverage and quality of the control program

Source: World Health Organization, *Framework for Effective Tuberculosis Control*, 1994 and World Bank, *TB at a Glance*, 2003.

1. World Health Organization, *Resolution WHA44.8 Tuberculosis Control Programme*, in Forty-Fourth World Health Assembly: Eleventh Plenary Meeting, Geneva, May 6–16, 1991.

1.3 In March of 1998, WHO convened the Ad Hoc Committee on the TB Epidemic to analyze reasons for the slow progress towards the 2000 targets, and to offer recommendations to the global community for accelerating improvement. Findings from this committee highlighted lack of political commitment as a major constraint to TB elimination, and called for a global charter on tuberculosis to solidify agreement between international agencies, donors and governments of endemic countries on a specific TB control strategy and timeframe. The committee also recommended that a Stop TB Initiative officially be established, along with a Global Drug Facility to facilitate procurement and distribution of drugs for use in the DOTS approach.

1.4 Resolution WHA51.13 of May 1998 officially launched an "Initiative" (which can be considered a precursor to the Stop TB Partnership), urging all Member States to take the necessary steps to meet the targets for 2000.[2] This Resolution enumerated the shortfalls of tuberculosis control at that time and promoted adherence to DOTS therapy as the most promising solution, particularly in the 17 high-burden countries not expected to reach the targets for 2000. The Resolution also outlined requests for action that go beyond the scope and capabilities of the DOTS strategy, including ensuring the supply of high quality anti-TB drugs, developing new networks and tools for the surveillance of multidrug resistance, and intensifying collaboration with UNAIDS and other agencies. Furthermore, during the implementation of these Resolutions, it became increasingly clear that an international partnership was required to undertake coordinated global action for TB control.

1.5 In March 2000, the Ministerial Conference on TB and Sustainable Development produced a core document, the Amsterdam Declaration to Stop TB, calling for accelerated action with time-bound targets to stop the spread of tuberculosis. Resolution WHA53.1 of May 2000 endorsed the establishment of the Stop TB Initiative, encouraged all Member States to endorse the Amsterdam Declaration, and extended the original 2000 targets to 2005.[3] In December 2000, Dr. J. W. Lee was appointed Director of the Stop TB Department at WHO.

1.6 In March 2001, the first Global Stop Tuberculosis Partners' Forum in Washington, DC, approved the formal structure of the Stop TB Partnership (including the establishment of six working groups: DOTS-Expansion; TB-HIV; DOTS-Plus MDR-TB; TB Drug Development; New Diagnostics; and New TB Vaccines), and officially launched the first Global Plan to Stop TB for 2001–2005. That same year, the Global Drug Facility was established to expand access to and availability of high-quality TB drugs to facilitate DOTS expansion. The Stop TB Partnership Coordinating Board met for the first time in February 2001 in Bellagio, Italy, and then in October 2001 in Annapolis, Maryland, USA.

1.7 In 2003, an evaluation report prepared for the Stop TB Initiative by the Institute for Health Sector Development in London was pivotal in solidifying the Partnership's

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2. World Health Organization, *Resolution WHA51.13 Agenda Item 20: Tuberculosis (A51/VR/10)*, in Fifty-First World Health Assembly: Tenth Plenary Meeting, Geneva: Regional Strategic Plan to Stop TB in the Western Pacific, May 16, 1998.

3. World Health Organization, *Resolution WHA53.1 Agenda Item 12.1 Stop Tuberculosis Initiative (A53/VR/7)*. In Fifty-Third World Health Assembly: Seventh Plenary Meeting, Geneva, May 19, 2000.

governance structure. The report helped to strengthen the Partnership's administrative skeleton, accountability mechanisms and formal regulations and procedures, moving Stop TB from an "initiative" to an organization. Nearly all of the report's recommendations have been implemented.

1.8 The Second Stop TB Partners' Forum was held in New Delhi in March 2004. The resulting New Delhi Pledge reaffirmed ministerial commitments to meet the 2005 targets, set urgent priorities for expanding DOTS coverage and for improving the management of TB-HIV and MDR-TB, and called for the creation of a second global plan to guide the Partnership towards achievement of the Millennium Development Goals for TB by 2015.[4] The WHA, echoing the concerns and priorities articulated in the Pledge, issued Resolution 58.14 of May 2005, encouraging the development of a global plan for the period 2006–2015.[5]

1.9 This Global Plan (2006–2015), officially accepted in January 2006, provides a comprehensive assessment of the actions and resources needed to implement the Stop TB Strategy[6] (which builds upon and enhances DOTS[7]), and seeks to reduce dramatically the global burden of TB.[8] The World Health Assembly, with Resolution 60.19 of May 2007, welcomed the second Global Plan and urged Member States to execute long-term plans for TB prevention focused on implementing high-quality DOTS, countering drug resistance, addressing TB related to HIV, strengthening health systems and laboratory capacity, and increasing the involvement of the private sector.[9]

1.10 A timeline of the actions taken during the period 1993–2008 to support global efforts to control/stop TB is given in Table 2. The Partnership was officially launched in 2001.

Program Objectives, Targets, and Strategies

OBJECTIVES

1.11 The mission of the Stop TB Partnership is to eliminate tuberculosis as a public health problem. Its stated vision is "a TB-free world: The children born this millennium will see TB

4. World Health Organization, *Fact Sheet on TB/HIV*, 2006.

5. World Health Organization, *Resolution WHA58.14 Sustainable Financing for Tuberculosis Prevention and Control*, in Fifty-Eighth World Health Assembly: Ninth Plenary Meeting, Committee A, Geneva, May 25, 2005.

6. The six components of the Stop TB Strategy are (1) Pursue high-quality DOTS expansion and enhancement; (2) Address TB/HIV,MDR-TB and other challenges; (3) Contribute to health system strengthening; (4) Engage all care providers; (5) Empower people with TB, and communities; (6) Enable and promote research. World Health Organization-Stop TB Partnership, *The Stop TB Strategy: Building On and Enhancing DOTS to Meet the TB-Related Millennium Development Goals*, 2006.

7. The five components of the DOTS approach are: (1) Political commitment with increased and sustained financing; (2) Case detection through quality-assured bacteriology; (3) Standardized treatment with supervision and patient support; (4) An effective drug supply and management system; and (5) Monitoring and evaluation system and impact measurement.

8. Stop TB Partnership, *The Global Plan to Stop TB 2006–2015: Actions for Life, Towards a World Free of Tuberculosis*, Geneva, 2006.

9. World Health Organization, *Resolution WHA60.19 Agenda Item 12.6 Tuberculosis Control: Progress and Long-Term Planning: (A60/VR/11*), in Sixtieth World Health Assembly: Eleventh Plenary Meeting, May 23, 2007.

Table 2. Evolution of the Stop TB Efforts

Date	Landmarks	Actions
1993	TB Emergency	TB declared a global health emergency by WHO
1995	DOTS	New approach to TB control developed: DOTS strategy
1998	Initiative	WHO launches Stop TB Initiative
2000	Declaration	20 high-TB burden country delegations and partners pledge in Amsterdam Declaration to develop a global partnership against TB (March 2000), which was endorsed by the World Health Assembly a few months later.
2001	Partnership Launch	Interim Coordinating Board devises a structure for the Partnership (February). The Global TB Drug Facility (March) is launched and Stop TB working groups are established. Stop TB First Partners' Forum (World Bank, October) endorses the Partnership Framework and launches Global Plan to Stop TB.
2003	Consolidation	Independent Partnership Evaluation finds "added value". 2nd Stop TB Partners' Forum (Delhi, March 2004) commits to accelerated action at the country level and endorses TB/MDG targets
2005	Expansion	Stop TB strategy diversifies approaches to reach MDG targets. Global Plan to Stop TB 2006–2015 outlines concrete budget and plan.
2008	Evaluation	Independent Evaluation of the Stop TB Partnership by McKinsey

Source: Author and Stop TB Partnership Web site (http://www.stoptb.org) and documents.

eliminated in their lifetime. Stop TB is a global movement to accelerate social and political action to stop the unnecessary spread of TB around the world."[10]

1.12 The specific objectives for which the Partnership has been accountable have evolved somewhat since 2001, and have recently been stated most clearly in the Global Plan to Stop TB, 2006–2015. But, since the present GPR covers the period from initiation of the program to the present, it has reviewed the achievements of the Stop TB Partnership against a set of objectives synthesized from core Partnership documents (Annex C). Objectives articulated in the Amsterdam Declaration (March 2000) and confirmed by World Health Assembly Resolution 53.1 guided the development of the first Global Plan to Stop TB 2001–2005 (Table 3). Partners gathered at the first Stop TB Partners' Forum issued the Washington Commitment to Stop TB in October 2001, which expanded the objectives to include effective responses to TB-HIV and MDR-TB, as well as initiating development of a second Global Plan, 2006–2015. On the whole, Stop TB's objectives have stayed remarkably consistent since 2001, with mostly minor adjustments over time.

1.13 The following set of objectives emerges from examination of key documents and is used for the purposes of this evaluation:

- Expand DOTS coverage to provide for at least 70 percent infectious case detection, and maintain a treatment success rate of at least 85 percent

10. Stop TB Partnership, *Amsterdam Declaration to Stop Tuberculosis*, from the Ministerial Conference on TB and Sustainable Development, Amsterdam, March 22–24, 2000.

- Improve procurement and distribution systems for TB drugs to ensure quality, access and timely supply
- Implement monitoring and evaluation systems for national TB programs in line with WHO standards
- Develop and scale-up effective responses to TB-HIV and to multidrug-resistant TB (MDR-TB)
- Accelerate basic and operational research for the development and delivery of new tools, including diagnostics, drugs and vaccines
- Promote the development of national and international partnerships to stop TB with all stakeholders in society
- Develop the Global Plan to Stop TB for the period 2006–2015.

Table 3. Evolution of Stop TB Partnership Objectives

Objectives: Amsterdam Declaration to Stop TB and Washington Commitment to Stop TB	**Objectives: Global Plan to Stop TB 2001–2005**	**Objectives: Global Plan to Stop TB 2006–2015**
Expand DOTS coverage to provide for at least 70% infectious case detection, and maintain a treatment success rate of at least 85%. Improve procurement and distribution systems for TB drugs to ensure quality, access, transparency, and timely supply. Implement monitoring and evaluation systems for national TB programs in line with WHO standards.	Expand DOTS strategy so that all people with TB have access to effective diagnosis and treatment	Increase access to accurate diagnosis and effective treatments by accelerating DOTS implementation to achieve the global targets for TB control. Increase the availability, affordability and quality of anti-TB drugs.
Develop and scale-up effective responses to TB-HIV and to multidrug-resistant TB (MDR-TB).	Adapt DOTS to meet the emerging challenges of HIV and drug resistance.	Adapt DOTS to prevent and manage MDR-TB, and to reduce the impact of HIV-related TB.
Accelerate basic and operational research for the development and delivery of new tools, including diagnostics, drugs and vaccines.	Improve existing tools by developing new diagnostics, new drugs, and a new vaccine.	Promote research and development for new TB drugs, diagnostics and vaccines. Promote adoption of new and improved tools by ensuring appropriate use, access and affordability.
Develop the Global Plan to Stop TB. Promote the development of national and international partnerships to stop TB with all stakeholders in society.	Strengthen the Global Partnership to Stop TB so that proven TB-control strategies are effectively applied.	Continue to strengthen the Stop TB Partnership.

Source: Stop TB Partnership, *The Global Plan to Stop TB 2001–2005,* Geneva, 2001; Stop TB Partnership, *Amsterdam Declaration to Stop TB,* from the Ministerial Conference on TB and Sustainable Development, Amsterdam, March 22–24, 2001; Stop TB Partnership, *Washington Commitment to Stop TB,* from the First Stop TB Partner's Forum, Washington, DC, October 22–23, 2001; Stop TB Partnership, *The Global Plan to Stop TB 2006–2015: Actions for Life, Towards a World Free of Tuberculosis*, Geneva, 2006.

TARGETS AND STRATEGIES

1.14 The Partnership's epidemiological impact targets are as follows:[11]

- By 2005: 70 percent of people with infectious TB will be diagnosed and 85 percent of them cured.
- By 2015: the global burden of TB disease (deaths and prevalence) will be reduced by 50 percent relative to 1990 levels.
- By 2050: The global incidence of TB disease will be less than 1 per million population (elimination of TB as a global public health problem).

1.15 The Partnership's strategies to achieve these targets are as follows:

- Promote wider and wiser use of existing strategies to interrupt TB transmission by (a) increasing access to accurate diagnosis and effective treatments by accelerating DOTS implementation to achieve the global targets for TB control, and (b) increasing the availability, affordability and quality of anti-TB drugs.
- Address the challenges posed by emerging threats by adapting DOTS to prevent and manage MDR-TB, and to reduce the impact of HIV-related TB.
- Accelerate elimination of TB by (a) promoting research and development for new TB drugs, diagnostics and vaccines, and (b) promoting adoption of new and improved tools by ensuring appropriate use, access and affordability.

Principal Partners

1.16 The Stop TB Partnership now has over 900 partners. This number grew from 7 at inception in 1998 to 40 in 2001 to 589 by mid-2007. Over 60 percent of the Partners are NGOs, with 150 national NGOs and numerous smaller organizations and community groups. Corporations, mostly pharmaceutical companies in the healthcare sector, make up 12 percent of the Partnership. The World Bank and the Global Fund have a significant presence in the Partnership, each occupying a permanent seat on the Coordinating Board. WHO has a unique dual role as both the lead policy agency with the Stop TB Department and a permanent member of the Coordinating Board, as well as the host agency of the Partnership's Secretariat.[12] A list of major partners is available in the Partners' Directory located on the Stop TB Web site (http://www.stoptb.org).

1.17 Criteria for membership in Stop TB was developed by the Secretariat and approved by the Board. Membership is open to organizations which "endorse the values and the principles of the Stop TB Partnership; support implementation of the Global Plan to Stop TB; are active in the area of TB, sustainable development and related fields and committed to collective action in the fight against TB; and advocate for the elimination of TB as a public

11. Targets and strategies as outlined in World Health Organization-Stop TB Partnership, *The Stop TB Strategy: Building On and Enhancing DOTS to Meet the TB-Related Millennium Development Goals,* 2006.

12. Stop TB Partnership. *Amsterdam Declaration to Stop Tuberculosis,* from the Ministerial Conference on TB and Sustainable Development, Amsterdam, March 22–24, 2000.

health threat at all levels"[13]. Individuals do not qualify for membership in the Stop TB Partnership. Members of Stop TB are referred to as Partners.

1.18 Organizations that wish to become Partners complete an online application form available on the Stop TB Web site (http://www.stoptb.org), which is then submitted to a Partnership officer at the Secretariat for review. Prospective Partners indicate affiliation with a specific constituency listed on the application form, as well as their desired areas of involvement in Stop TB. (See Coordinating Board constituencies in Table 4.) Partners are catalogued and profiled in the Partners' Directory (accessible online at http://www.stoptb.org), including the organization's contact information, description and declaration of interest in Stop TB.

1.19 Since 2005, the Partnership has formalized relationships through several Memorandums of Understanding (MoU) with key contributors to the global fight against TB. A MoU with the Global Fund to Fight AIDS, Tuberculosis and Malaria (signed in May 2005) reinforced the role of the Green Light Committee [technical and policy support to WHO to prevent the spread of TB drug resistance] in controlling access to second line drugs. A MoU with the World Economic Forum (October 2006) delineated collaboration between the WEF and the Partnership, and formalized the WEF as the Coordinating Board's corporate constituency, facilitating engagement of the corporate sector in TB control. In June 2007, the Partnership established a MoU with World Care Council, and collaborated with UNITAID in the organization's pledge to fund efforts in second-line drugs and pediatric tuberculosis.

Governance and Financing Arrangements

GOVERNANCE

1.20 The *Basic Framework on the Stop TB Partnership*[14] is considered the Partnership's founding document and outlines its governance structure. While not a formal charter or legally binding document, the *Framework* describes the Partnership's institutional, operational and administrative arrangements along the lines of its four core entities: the Partners' Forum, the Coordinating Board, several Working Groups, and the Secretariat.

1.21 The **Partners' Forum** is the "General Assembly" of the Stop TB Partnership (Figure 1). It meets every three years and includes representatives of all the Partners as well as other interested parties invited by the Executive Secretary. The Forum works to increase collaboration among Partners, to focus commitment on achievement of the Partnership's objectives, to track the Partnership's progress, and to serve as an "open forum for information exchange". The Forum formalizes commitments, particularly high-level political commitments, to targets and strategic plans; reviews and makes recommendations on Board reports; and creates and, most importantly, expands upon opportunities for advocacy and communication in promotion of the Partnership's goals.

13. Membership Criteria: http:///www.Stoptb.org.

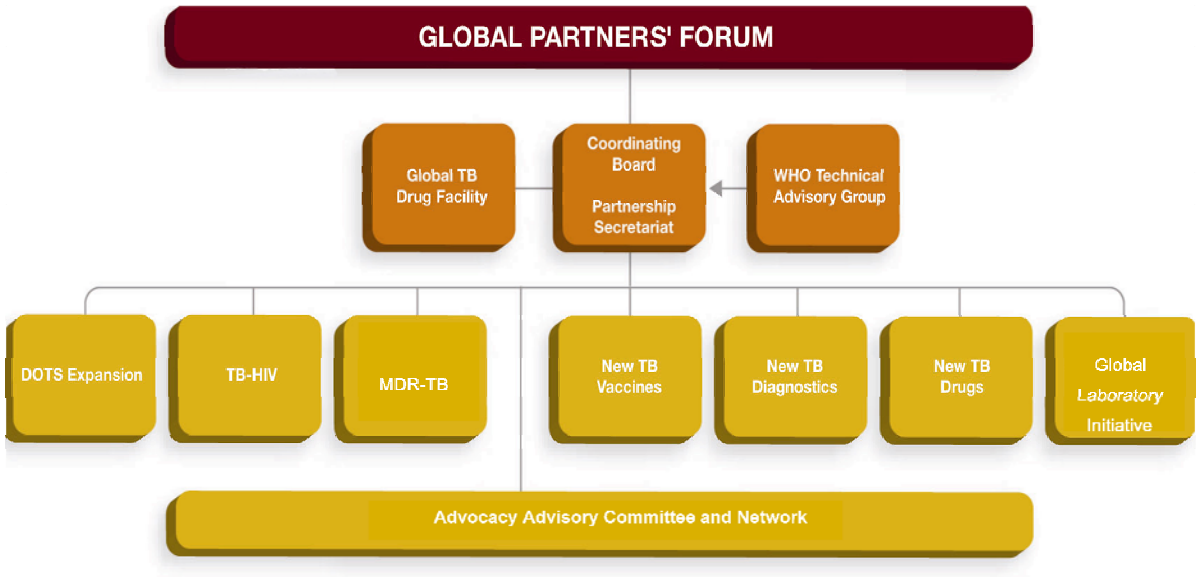
14. *Basic Framework* accessible on the Stop TB website, http://www.stoptb.org/cb/assets/documents/STBBasicFrameworkrevFinal10Aug04.pdf.

Table 4. Composition of the Stop TB Coordinating Board

Constituency	No.	Board Member *(July 2009)*	Modus of Appointment
High-TB burden countries	4	*China* *South Africa* *Myanmar* *Tanzania*	Selected *(Executive Secretary leads consultation process with CB and WHO Regional representatives for selection)*
Multilateral Organizations	3	WHO World Bank Global Fund	Permanent
Other International Organization	1	*UNAIDS*	Selected
Regional Representatives	6	African Region American Region Eastern Mediterranean Region European Region South-East Asia Region Western Pacific Region	Selected *(Executive Secretary leads consultation process with CB and WHO Regional representatives for selection)*
Stop TB Working Group Chairs	7	DOTS Expansion WG (DEWG) TB/HIV WG WG on MDRTB WG on New TB Vaccines WG on New TB Diagnostics WG on New TB Drugs Global TB Laboratory Initiative	Permanent *(each chair is elected on a term basis as part of process within each individual Working Group)*
NGO's/Technical Agencies	3	IUATLD CDC *Elected NGO member*	Permanent Permanent Elected *(online lead by permanent NGO/TA members)*
Financial Donors	5	USA Canada *Japan* *Italy* *Netherlands*	Elected /1
Foundations	1	*BM Gates Foundation*	Elected
Corporate Business Sector	1	*Merieux Alliance*	Elected *(process managed by World Economic Forum Secretariat)*
Communities Affected by TB	2	*NGO, Pakistan* *TB/HIV activist, Zambia*	Elected
WHO Strategic Technical Advisory Group (STAG)	1		Permanent

Source: Stop TB Web site, http://www.stoptb.org.
/1 USA and Canada have been semi-permanent members since inception.

Figure 1. Stop TB Partnership Structure



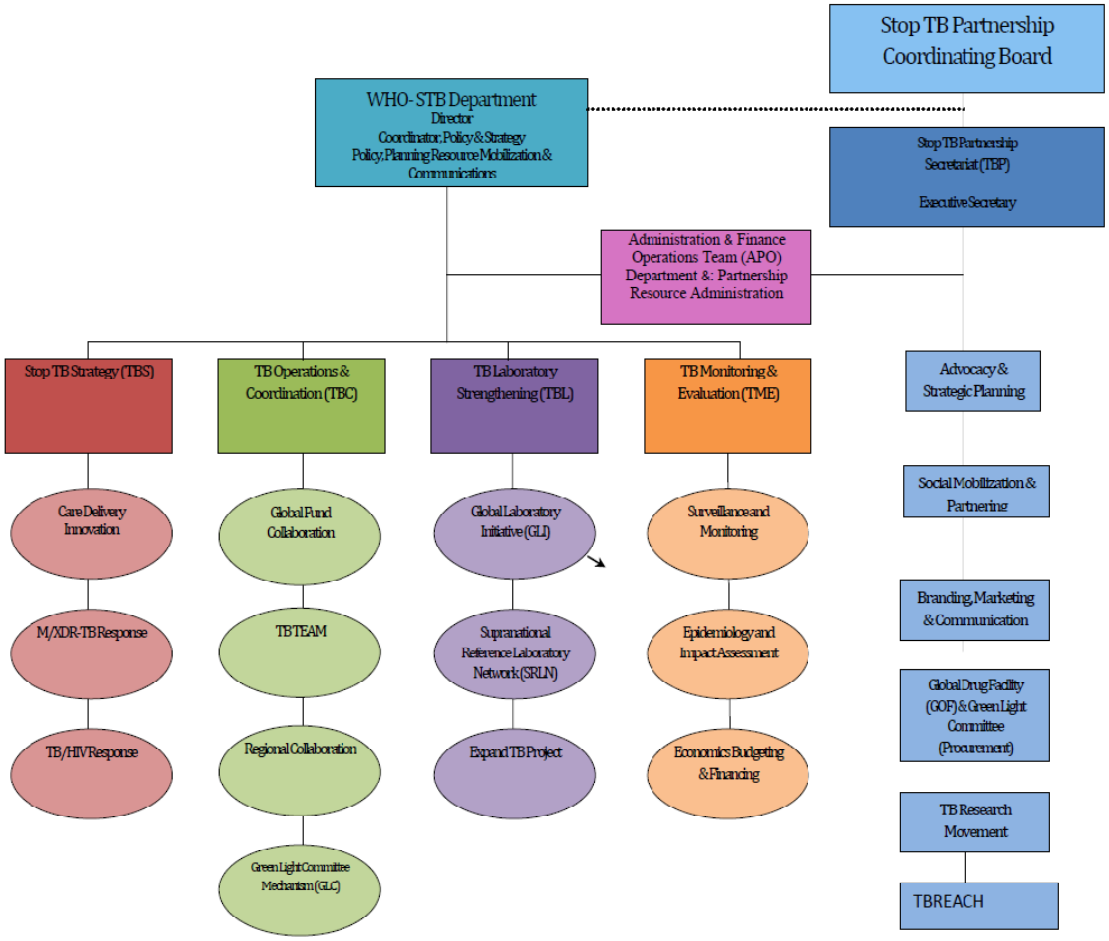
Source: Stop TB Secretariat.

1.22 The constituency-based **Coordinating Board** meets semi-annually and provides leadership in monitoring and directing implementation of the Partnership's policies, plans and activities. It plays a central role in the coordination of Partnership components. The Board prioritizes areas for action and supports the Partnership in achieving its established aims through (a) resource mobilization; (b) oversight and review of the Secretariat's work plan, budget and implementation; (c) adoption of financial policies to guide the Secretariat's actions; (d) advocacy coordination; (e) establishment of committees, working groups, and task forces as necessary; and (f) external representation of the Stop TB Partnership. The venue rotates for each Board meeting, including to developing countries, and there is consistently high participation.

1.23 The make-up of the Coordinating Board reflects the component constituencies of the Partnership. Representatives are either elected or selected based on constituency type (). The Board is currently comprised of 34 members, including 4 representatives from high-burden countries; one each from the WHO, the World Bank, and the Global Fund; one other international organization representative; 6 regional representatives; 7 Working Group Chairpersons; 5 representatives of financial donors; 1 representative of Foundations; 3 NGOs and technical agencies (including the Union and CDC as permanent members); 2 representatives of communities affected by TB; the Chair of WHO Strategic and Technical Advisory Group for Tuberculosis (STAG); and one representative from the corporate business sector. The Board appoints seven of its members who, including the Director of the WHO TB Department, make up the Executive Committee (ExComm) that acts on behalf of the Board between formal sessions. Currently, the Executive Committee has representatives from USAID, CDC, WHO, the Foundation for Innovative Diagnostics (FIND), the Ministry of Health of Kenya, Universidad Nacional Autonoma de Mexico, and the Bill and Melinda Gates Foundation's Global Health Program.

1.24 The **Secretariat** at WHO provides administrative, operational and strategic support to the Partnership, and is accountable to the Coordinating Board (Figure 2). Its work is focused on partnership building, advocacy, communication and social mobilization, investment mechanisms, resource coordination and mobilization, and drug supply. The Secretariat manages the GDF (including application review and monitoring, drug supply management, and general management and support to GDF operations) and also facilitates the activities of and collaboration between the Working Groups. The transactional nature of the Secretariat's functioning catalyzes Working Group/Partner action toward achievement of Global Plan objectives. The Secretariat coordinates major Partnership initiatives such as the planning and writing of the Global Plan to Stop TB and the large-scale advocacy campaign for World TB Day each year. The Executive Secretary prepares an annual global strategic work plan for the Secretariat subject to Board approval, including plans and budget for the Secretariat and any group established by the Board. Dr. Marcos Espinal currently holds the position of Executive Secretary.

Figure 2. Stop TB Secretariat and WHO Stop TB Department — Organizational Chart



*Source: A*dapted from WHO Stop TB Department organizational outline.

1.25 The program includes seven **Working Groups** for research, advocacy, and/or operational functions particular to the group's specific area of interest and in promotion of the Partnership's overall goals. The groups are: DOTS Expansion Working Group; TB-HIV Working Group; Stop TB Working Group on MDR-TB; Working Group on New TB Drugs; Working Group on New TB Diagnostics; Working Group on New TB Vaccines; GLI and Advocacy, Communication and Social Mobilization Working Group (disbanded January 2009). These groups collaborate with other areas of the Partnership to improve coordination and add value to Partnership activities. They play a central role in advocacy, building consensus and commitment, and partnering with the commercial private sector (i.e., drug companies) as well as the non-profit private sector (i.e., foundations). The three New Tools Working Groups (New TB Vaccines, New TB Drugs, and New TB Diagnostics) largely consist of commercial private partners who collaborate to advance their companies' agendas in alignment with the Global Plan to Stop TB. As such, the partnering is about common goals and not simply an effort to build a bridge to the commercial sector to advance the public agenda.

1.26 Four of the Working Groups (DOTS Expansion, TB-HIV, BDR-TB, and Global Laboratory) are administered by WHO, while the groups dealing with the private sector (New TB Drugs, Diagnostics, and Vaccines) are administered by the Secretariat.

1.27 The **Global Drug Facility** — housed at WHO headquarters in Geneva and managed by a small team in the Stop TB Partnership Secretariat — is an innovative mechanism that aims to ensure uninterrupted access to high-quality anti-TB drugs for national TB control programs to catalyze DOTS expansion. The GDF facilitates procurement of high-quality drugs at a relatively low cost through grant-making and Direct Procurement services, and provides both technical assistance and quality assurance to countries. All services are competitively outsourced to reduce costs and drug supply is directly linked to national TB program performance. The GDF operates three core services:

- **Grant-making:** Qualifying countries (GNI < 3000 with priority to those with GNI < 1000) and NGOs working with national health ministries in these countries are eligible to apply for GDF grants, and must complete an application including information on TB drug needs, a description of a DOTS expansion plan and the national TB program, country statistics on TB, and plans for drug distribution. Once approved, a GDF team meets with government officials in-country to evaluate drug needs and distribution capacity, and the application can then officially be approved and terms and conditions of the grant finalized.
- **Direct Procurement:** Countries that are implementing the DOTS strategy in 90 percent of the population, and NGOs and donors supporting these countries, can utilize the Direct Procurement service to access quality TB drugs with their own resources through a reliable procurement agent and benefit from GDF-secured low prices and quality assurance.
- **GDF Technical Support Service:** GDF mobilizes Stop TB partners to provide technical assistance for in-country management and monitoring of anti-TB drugs, and supports global efforts to improve drug quality primarily through WHO pre-qualification.

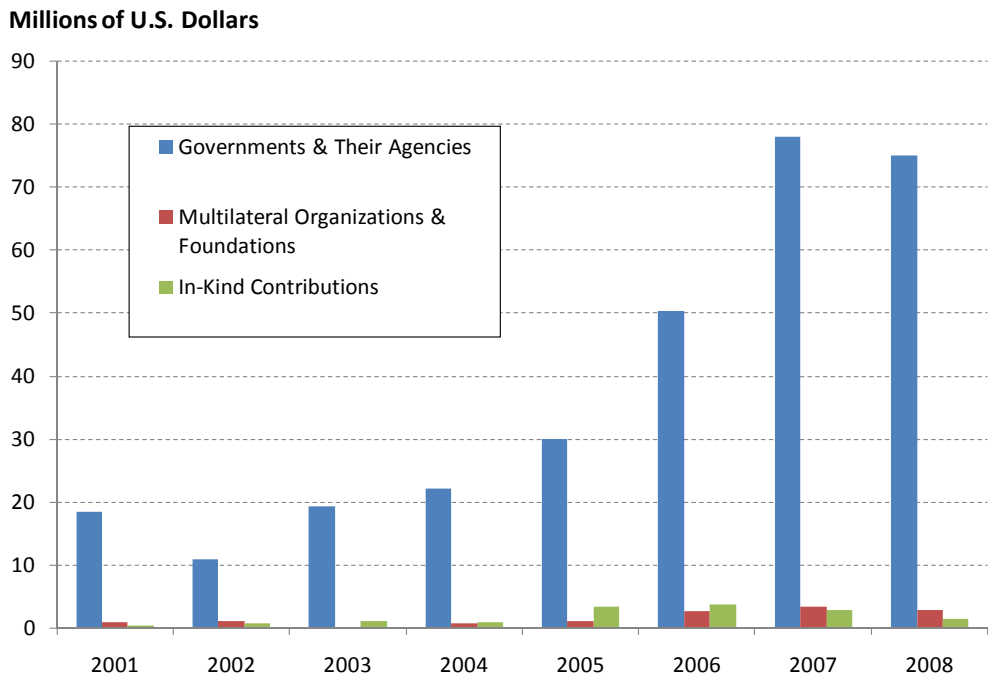
1.28 In 2006, the Global Drug Facility expanded its catalogue to include second-line anti-TB drugs to treat multi-drug resistant TB (MDR-TB). The GDF serves as the drug procurement and management arm of the Green Light Committee Initiative.

1.29 The **Green Light Committee Initiative**, launched in 2000, promotes access to and rational use of second-line anti-TB drugs in resource-limited settings to prevent the spread of drug resistance. The Initiative consists of a Secretariat (hosted and administered by WHO), the Green Light Committee and the Global Drug Facility (drug procurement for GLC-approved programs). The Green Light Committee, in concert with the Working Group on MDR-TB, reviews applications and supports technical assistance for MDR-TB programs, provides monitoring and evaluation of these programs, and assists WHO in policy formulation for the management and prevention of MDR-TB.

FINANCING ARRANGEMENTS

1.30 Bilateral donors contribute the largest source of funding to the Stop TB Partnership (69 percent for the period 1999–2004).[15] Regular major bilateral donors include the USA, Canada, the Netherlands, and the United Kingdom. Of multilateral organizations, the World Bank has made a regular annual contribution of $700,000 since the Partnership's inception (Figure 3).

Figure 3. Stop TB Partnership: Income,/1 2001–2008



Source: Stop TB Partnership Annual Reports, and Annex K.
/1 Income excludes costs for Direct Procurement through the Global Drug Facility.

15. Stop TB Partnership and HLSP Institute. *Trends in International Funding for TB Control*. Resource Mobilization Task Force of the Stop TB Partnership, 2005.

1.31 Annex K provides detailed income and expenditure statements for the Secretariat (excluding the Global Drug Facility), as well as for the GDF. The Global Drug Facility constitutes the majority of Partnership expenditures. In 2007, new relationships were forged with the recently-created UNITAID[16] and the Global Fund, including a major funding agreement with UNITAID for US$53.3 million.

2. External Evaluation of the Stop TB Partnership

Scope, Process, and Approach

2.1 The Independent External Evaluation of the Stop TB Partnership, carried out by a team from McKinsey & Company in 2008 (final report of April 21, 2008), was commissioned and financed by the Coordinating Board of the Partnership. The WHO issued a Request for Proposals (RFP) on behalf of the Board on March 20, 2007. Responsibility for managing the evaluation was delegated by the Partnership to an eight-member sub-committee of the Board, the Evaluation Steering Committee (ESC), with the Secretariat providing technical and administrative support to the ESC. The final selection of the winning bid was approved by the WHO Contract Review Committee. The evaluation, which cost approximately US$1 million, was paid for by Stop TB Partnership program funds.

2.2 The external evaluation team conducted 94 interviews with active participants in tuberculosis control and prevention at the global level, visited 8 countries (India, China, Indonesia, Burkina Faso, Uzbekistan, Peru, Kenya, Morocco), and conducted over 150 in-country interviews. It reviewed pertinent publications and other documents of the Stop TB Partnership, the WHO Stop TB Department, and other relevant materials. Data analysis covered various aspects of the Partnership's work, including tuberculosis epidemiology, control metrics, funding, advocacy, and research and development. In addition, the evaluation team conducted an internet-based survey of 1,332 stakeholders, for which it received an overall response rate of 17 percent. The response rate from each category of respondents was as follows: national control program managers (9 percent), Secretariat staff (61 percent), and members of the Coordinating Board (45 percent). Evaluation Team members attended the October 2007 meeting of the Coordinating Board in Berlin, as well as the November 2007 International Union Against TB and Lung Disease Conference in Cape Town. A draft report was circulated for comments at the end of 2007 and feedback was received from the Coordinating Board. The report was finalized in April 2008.

Independence and Quality

2.3 The evaluation team and report were independent of the Stop TB Secretariat. The evaluation terms of reference drafted by the Stop TB Secretariat were approved by the Coordinating Board. The Evaluation Steering Committee, in cooperation with the Stop TB

16. UNITAID (www.unitaid.eu) was established in 2006 to support existing efforts to achieve the MDGs. Specifically, it is a financing mechanism focused on leveraging price reductions to provide long-term, sustainable and predictable funding to increase access and reduce prices of quality drugs and diagnostics for the treatment of HIV/AIDS, malaria, and TB in developing countries.

Executive Committee, managed the bidding, selection and briefing process, and provided guidance to the evaluation team (including feedback on the final draft evaluation report submitted at the end of the evaluation process). The full text of the evaluation report has been disclosed on the Stop TB Partnership Web site (http://www.stoptb.org).

2.4 The evaluation TOR articulated two purposes of the evaluation in very broad terms — assessing the impact of the Partnership and recommending how to improve its effectiveness and efficiency — and presented an ambitious set of questions to be answered. The TOR did not provide an evaluation framework, but specifically relied upon the evaluation team to devise an appropriate assessment methodology.

2.5 Several issues arose during the evaluation process. In response to the RFP,[17] the evaluation team pointed to the inherent difficulties of reconciling a "cross-sectional" evaluation conducted over a short time-frame with the interest of the program in exploring outcome-level variables requiring a different evaluation methodology. The evaluation team also confronted three issues at the outset of its work, as illustrated by Exhibits 1, 2 and 3 in their final evaluation report: (a) the lack of a set of explicit objectives for the Partnership itself, (b) the boundaries of the Partnership, and (c) a cumbersome terms of reference. Faced with these issues, which made it difficult to do an "objectives-based evaluation", the evaluation team developed its own evaluation approach, which may be characterized as a "results-based" rather than an "objectives-based", to which the Evaluation Steering Committee agreed.

2.6 The evaluation team defined the Partnership as a "set of defined bodies specific to the Partnership" — that is, the Coordinating Board, the Secretariat, the Working Groups, etc. (which are distinct from individual Partners). In terms of measuring the Partnership's achievements against its objectives, the evaluation noted the objectives of the Global Plans to Stop TB for 2001–06 and 2006–15, but did not specifically use these objectives as a framework for the evaluation or relate its assessment to these objectives. Rather, the evaluation formulated a set of six consecutive questions (Table 5) to assess the Partnership's past performance. The final evaluation report also provides an understanding of the future landscape in which the Partnership will likely operate. The team developed three scenarios for the TB landscape until 2015, outlined their current and future implications for the Partnership, and formulated recommendations.

2.7 IEG finds the evaluation's "results-based" methodology to be appropriate given the lack of a set of explicit objectives for the Partnership itself as well as the cumbersome evaluation TOR. That the evaluation report did not answer all of the evaluation questions in the TOR should be attributed primarily to the nature of the TOR as opposed to a weakness in the evaluation team's work. And the team should be credited with devising an evaluation approach and framework which made it possible to conduct the evaluation within the given time period. Also, the team was correct to direct substantial focus onto the value of the Partnership's processes. Global partnerships are inherently process-oriented and complex, and a core contribution of Stop TB seems to lie in the legitimacy, reliability and clarity of its

17. RFP Number 4892 – *Independent Evaluation of the Global Stop TB Partnership* – Questions from prospective bidders and Stop TB response.

Table 5. Overall Evaluation Framework Used by the External Evaluation Team

<table>
<tr><th>Data Gathering and Analysis</th><th>Synthesis and Prioritization</th><th>Developing Recommendations</th></tr>
<tr><td rowspan="2">1. What impact has Stop TB had in 2001–06 over and above what would have happened without Stop TB?
• Change in TB impact metrics
• Stop TB “share” of these changes</td><td></td><td rowspan="2"></td></tr>
<tr><td rowspan="3">4. Based on this analysis, where should Stop TB adjust its strategic focus and scope of activities to maximize its impact over the next 5–7 years?</td></tr>
<tr><td>2. How has the TB landscape changed over 2001–06, and what are the future implications?
• Disease/treatment (e.g., TB/HIV)
• Stakeholders (e.g., new donors, new partnerships)</td><td rowspan="3">6. What are the specific recommendations to Stop TB to improve its performance?
• Strategic focus
• Scope of activities
• Operational processes
• Resources
• Organization structure
• Governance</td></tr>
<tr><td rowspan="2">3. How effectively and efficiently has Stop TB delivered this impact?
• Along key performance metrics for structure, operations, and governance
• Based on stakeholder feedback</td><td rowspan="2">5. Based on this analysis, where should Stop TB improve the effectiveness and efficiency of its structure, operations, and governance?</td></tr>
<tr><td></td><td></td></tr>
</table>

Source: McKinsey & Company, Independent Evaluation of the Stop TB Partnership, Exhibit 3.

processes, which have been agreed upon and adhered to by the partners, thereby facilitating the results achieved and documented in the evaluation.

2.8 The evaluation report was quite comprehensive in dealing with the key aspects of the Partnership, and clearly conceptualized why the Partnership has added value and where it has had impact. The report succinctly addressed issues relating to the overall objectives, goals, governance, and structure, and provided clear guidance for the Partnership. Examples included detailed recommendations for strengthening the Working Groups in guiding the Partnership on various technical matters, and suggestions for subcommittees to facilitate decision-making within the Coordinating Group.

2.9 The evaluation team’s strength as “traditional” management consultant may have impaired its ability to address epidemiological aspects of the Partnership’s work and to respond more systematically to evaluation questions related to this important component of Stop TB.

2.10 The evaluation report could have dealt more comprehensively with operational and policy issues related to the Global Drug Facility (GDF). The team offered a detailed overview of the GDF’s structure and function, based on GDF documents and some in-country interviews, and appropriately described the issues facing the GDF. However, the report’s largely descriptive discussion lacked an independent assessment of the GDF, an area in which operational recommendations were warranted and would have been most useful. The evaluation failed to address the Global Drug Facility’s subsidiarity and scope of activities, including the appropriateness and effectiveness of utilizing multiple channels for procuring drugs for TB control and potential user charges for direct procurement.

2.11 Unfortunately, the evaluation report is not particularly user-friendly, specifically with respect to the large volume of annexes. It would have benefited from such simple devices as a table of contents for the numerous annexes, and liberal use of cross-references in the main text to data in the annexes which support the findings and conclusions of the report. Had this been done, it would have been much easier to correlate the annex tables to the text, and to more easily link the conclusions and related data. To partially overcome this limitation, the Evaluation Steering Committee did a very good job of outlining in detail the report's recommendations and presenting them in a clear and concise format.

Major Findings and Recommendations, and the Stop TB Partnership's Response

FINDINGS

2.12 The team concluded that during 2001–2006 the "Partnership contributed significantly to the global effort to stop TB", and that it added much value to what would have been achieved in tuberculosis control and research in its absence.

2.13 The report is very specific about areas in which the Partnership has been strong (broadening out from a technical consensus, fostering an inclusive, collaborative approach, focusing on adding value, and adopting innovative approaches) as well as area where it has been less effective such as setting objectives, coordinating activities and reviewing performance.

2.14 The evaluation found that the Partnership had achieved results in five areas:

(1) *Expanding and strengthening the Partnership*: The Partnership was launched with 7 partners and has since increased to 600 partners in mid 2007. It strengthened relationships with a broad range of organizations involved in TB control and research including the corporate sector, the Global Fund, the World Economic Forum and UNITAID.

(2) *Broadening the agenda, increasing consensus and strengthening guidance for TB control and research*: In particular, it has raised awareness of TB-HIV, MDR-TB, and articulated a unified framework for action in the Global Plans. The WG were instrumental in the development of the plans, which are now considered the standard framework for national tuberculosis control plans and a *de facto* framework for applications to the Global Fund. In these efforts, the Partnership has not encroached on the roles of WHO, The Union, KNCV, etc. in providing normative, technical or other guidance.

(3) *Expanding the reach and impact of global advocacy*: The Partnership has succeeded in including tuberculosis on the agenda of major international summits, such as two G8 summits. More importantly, it has massively increased the political visibility of TB through media, TB ambassadors, High Level Missions to countries, etc. This has resulted in doubled funding for TB as measured by National TB Control Program (NTP) budgets in high-burden countries between 2002 and 2007 from $420 to $999 million.

(4) *Coordinating and supporting Partners' activities in key areas such as technical assistance to countries, monitoring and evaluation, and research and development*: Partner activities, such as provision of technical assistance to countries, are coordinated to draw on respective comparative advantages. Tuberculosis control metrics have been improved, and data for TB are now more comprehensive than for many other diseases. Research and development of new tools (drugs, diagnostics and vaccines) has increased significantly over the evaluation period, and funding for new tools has increased from $125 million in 2000 to $750 million in 2006. Product Development Partnerships, such as TB Alliance, FIND and AREAS play the leading role along with funding from the Bill and Melinda Gates Foundation.

(5) *Improving TB control in countries directly*: The evaluation is based on visits to eight countries, mapping out the progress of control against a series of drivers and then assessing the Partnership's contribution. On average, there has been major progress in resource mobilization and improving access to and availability of high quality drugs. There has been relatively less progress on MDR-TB.

2.15 The evaluation report also commented on drivers of the Partnership's achievements, listing four primary factors. The report pointed to the early technical consensus around WHO's DOTS strategy, as well as the inclusive and collaborative approach by which the Partnership actively encouraged constituency participation and provided a range of forums for collaboration. The program has also focused on innovation and avoided taking over the roles of its Partners. The evaluation points out as well the failures of the Partnership, particularly the insufficient clarity on the objectives of some of the Working Groups, lack of appropriate metrics and targets to measure some of the achievements, and insufficient efforts to catalyze broader country improvement in drug funding and procurement.

RECOMMENDATIONS

2.16 The team's recommendations were based on its generally positive evaluation of the Partnership. The team recommended few changes to what the Partnership does, but significant changes to how it operates. The major thrusts of their recommendations are as follows:

(1) Invest more effort in data and analysis to *identify and agree on the biggest opportunities to drive progress in TB control and research* (e.g., *specific* countries' commitment, *specific* technical and managerial issues), and to drive consensus and commitment on the actions that countries, other Partners, and the Partnership and its bodies must undertake to realize these opportunities.

(2) *Integrate the strategies of individual Partnership bodies into a unifying Partnership strategy* that clearly lays out what the Partnership aims to deliver and how it will do so. This is distinct from the Global Plan, which lays out what needs to be done, and from the individual strategies of Partnership bodies.

(3) *Concentrate Partnership effort and resources* on delivering on the big opportunities identified above, rather than spreading too thin across too many issues.

(4) *Maximize the use of Partnership levers to influence countries, Partners, and other*

actors and to hold them to account for delivering on commitments: performance transparency, strong advocacy, and leverage of GDF grants in-kind.

(5) *Increase performance transparency* regarding the impact and efficiency of the Partnership and its bodies to ensure optimal use of Partnership resources.

2.17 The evaluation report then lays out 10 broad recommendations, each one containing a series of detailed operational recommendations. They focus on the role of the Partnership in advocacy and technical assistance, activities of Partnership bodies including GDF and GLC, and the structure, management and governance of the Partnership (see Annex H).

RESPONSE OF THE PARTNERSHIP TO THE EVALUATION REPORT'S RECOMMENDATIONS

2.18 The evaluation was positively received by the Partnership and the detailed recommendations were carefully reviewed by the Evaluation Steering Committee. The Board meeting in spring 2008 in Cairo formally accepted the evaluation report. A subsequent meeting in Bagamoyo in the fall of 2008 followed up on a series of specific recommendations, including a high-level meeting on MDR-TB, the future of the WGs, second-line drug management and support, the impact assessment task force, cooperation with the Global Fund, and others. Some recommendations regarding the Board's structure have not been accepted by the Partnership, including recommendations to restructure the Board to reflect the significant number of NGOs in the Partnership and to institute decision-making by voting as opposed to consensus.

2.19 One area to highlight is the Partnership's positive response to the evaluation's detailed recommendations on the Working Groups. The report found that the Advocacy Communication and Social Mobilization Working Group unnecessarily duplicated functions, since the Secretariat carried out advocacy and communication for TB, particularly at the global level, and other working groups, product development partnerships and individual partners also did so for their own areas of focus. Additionally, the ACSM WG was not appropriate as a fundraising entity. The evaluation recommended that the Secretariat and ACSM WG work together to avoid overlap of activities, either by developing a clearly non-duplicative remit for the WG, or by absorbing WG activities into the Secretariat's Advocacy Unit and the Coordinating Board subcommittee on Advocacy. After considerable discussion of divergent opinions, the Board followed up on this recommendation and acted to disassemble the ACSM Working Group and reassign its functions.

2.20 In addition, the Board subsequently established a new Global Laboratory Initiative[18] with a sub-group on infection control (created as a full Working Group in October 2008). This reflects the important flexible nature of the Working Group concept, as well as the responsiveness of the Board in examining the functioning of various WGs and modifying their number and scope of work in response to the changing needs of Stop TB and its partners.

18. The major objectives of the Global Laboratory Initiative (GLI) include providing global standards for laboratory services, promoting quality assurance and adequate laboratory biosafety, accelerating human resource development for laboratory activities, and facilitating partnerships that will enable the establishment of expansion of laboratory services capable of absorbing new technologies. Its secretariat is housed at WHO. From World Health Organization, *Global Tuberculosis Control 2009: Epidemiology, Strategy, Financing*. 2009: Geneva.

3. The Effectiveness of the Stop TB Partnership

Relevance

3.1 Once a “forgotten disease”, tuberculosis has re-emerged on a global scale and is presently one of the leading causes of death from infectious disease worldwide, significantly contributing to poverty, straining health systems and inhibiting development. In the early 1990s, morbidity data began to reveal the true magnitude of the global TB burden, and re-established TB as a major disease problem. The major issues which surfaced — namely, the insecurity of drug supply, limited involvement of the private sector, gradually emerging first-line resistance, and HIV/AIDS as an amplifier of TB incidence and spread — revealed that the narrowly-defined and incompletely-applied DOTS strategy was only partially effective. The majority of the treatment for TB patients was occurring in the private sector, with considerable treatment variation. Incomplete treatments due to drug shortages and varying regimes were contributing to the emergence of tuberculosis strains (MDR-TB and XDR-TB) that were resistant to traditional drug treatments.

3.2 In this context, the objectives of the Stop TB Partnership are highly relevant. To begin with, its vision of eliminating tuberculosis as a public health problem is fully consistent with current global challenges and priorities in the health sector. The Millennium Development Goals adopted by the United Nations at the turn of the millennium gave much attention to health in general and to reducing the incidence of infectious diseases in particular. The Amsterdam Declaration (March 2000), the World Health Assembly Resolution 53.1 (May 2000), the first Global Plan to Stop TB (2001-2005), and the second Global Plan to Stop TB (2006–2015) all reflect an international consensus on the need for collective action to mitigate the spread, reduce the incidence and ultimately eliminate tuberculosis as a public health issue. Donors such as the Global Fund, UNITAID and the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), as well as governments of endemic and non-endemic countries have also increased their contributions to tuberculosis control.

3.3 The voice of developing and transition countries is fully reflected in the international consensus underlying the program, for example, in the Amsterdam Declaration (March 2000). The Ministers of Health, Planning, and Finance from the 20 countries home to 80 percent of the world’s TB cases unanimously committed themselves to meet the objective of expanding DOTS coverage to provide for at least 70 percent detection of all infectious TB cases by 2005. These goals and the commitment to achieve them remain important.

3.4 An international consensus exists, not only on the need for action but also on the nature of the problem, on priorities and strategies for action. The first priority for effective TB control — and a central feature of the Partnership’s work — is improved coordination to develop uniform protocols to expand DOTS coverage and to address the spread of resistance. DOTS coverage and treatment targets largely have been achieved, but the significant spread in the severity and range of drug-resistant TB has grown in importance since the Partnership’s inception. In response to this, the Stop TB Partnership, along with WHO, launched the special Global MDR-TB and XDR-TB Response Plan 2007–2008.

3.5 The increase in co-infection of TB with HIV/AIDS is also an urgent priority. The *annual* relative risk of developing TB is 5–10 percent for HIV/AIDS patients, compared to the *lifetime* risk of 10 percent for non-HIV infected individuals.[19] The increasing burden of TB-HIV, along with pressing diagnostic issues, requires a more comprehensive tuberculosis control strategy.

3.6 More generally, it is now realized that tuberculosis cannot be controlled with existing tools. The six-month long combination therapy (short-course chemotherapy) is demanding on the patient and new drugs are urgently required. The emphasis on new tools and the investment in research that the Partnership has catalyzed must be maintained for years to come.

3.7 The Partnership's strategies and priority activities, as outlined in the Global Plan to Stop TB (2006–2015), are appropriate for meeting the 2015 tuberculosis-related MDG and Stop TB Partnership target of halving prevalence and mortality with respect to 1990 levels. The majority of Partnership efforts have focused on filling gaps, such as global advocacy and enhanced access to high-quality drugs through the Global Drug Facility and Green Light Committee. Partnership activities do not compete with or substitute for activities that individual donors or countries could accomplish more efficiently on their own.

3.8 The Stop TB Green Light Committee (GLC) has been recognized internationally as the appropriate and most effective body to deal with access to second-line anti-TB drugs to prevent the spread of resistance. A memorandum of understanding with the Global Fund (May 2005) explicitly acknowledges the GLC as the gatekeeper of access to second-line drugs, as well as the value of the unique package of services provided by the Global Drug Facility for high-quality procurement and technical assistance.

3.9 Recognizing the diversity of mandates and capabilities among partners, the Partnership does not attempt to duplicate actions, such as providing country and local-level technical assistance. The Partnership provides a range of forums for collaboration and endorses WHO's normative guidelines as opposed to issuing its own. The Partnership engages bodies involved in service provision and research without attempting to govern, as individual partners retain their own accountability and governance mechanisms. The relatively loose nature of the Partnership draws on partner resources and expertise in such areas as knowledge sharing, networking, research and development, and providing technical assistance.

3.10 The Stop TB Partnership continues to represent a broad range of constituencies including donor countries, international organizations, high-burden countries, non-governmental organizations, and patient groups. Partnership bodies come together to forge technical consensus in a pluralistic environment and formulate clear agreement on treatment standards and approach, place TB on the political and development agenda, and develop and utilize new clinical tools (drugs, vaccines, and diagnostics) to advance tuberculosis control worldwide.

19. World Health Organization, *Fact Sheet on TB/HIV*, 2006.

Table 6. Partnership Objectives, Activities, Outputs and Outcomes

Objectives /1	**Activities**	**Outputs**	**Outcomes**
1. Expand the DOTS strategy so that all people with TB have access to effective diagnosis and treatment: a. Accelerate implementation to provide for at least 70% infectious case detection, and maintain a treatment success rate of at least 85%	• DOTS Expansion Working Group (created 2000) • National TB Programs • Global Plan 2001–2005 • Global Plan 2006–2015 • Stop TB Strategy	**DOTS Coverage** • Total number of countries implementing DOTS: 187 • DOTS implementation in 22 HBCs reported at 98% of cases treated **Case Detection Rate (smear-positive cases)** • 43% (2001) → 64% (2007) • Case detection rate ≥ 70% in Western Pacific Region (78%), the Americas (76%), and Southeast Asia (69%) • Case detection rate < 70% in European Region (55%) /2 and African Region (47%) **Treatment Success Rate** • Target reached globally in 2006 (85%)	**Prevalence** • 262 (2001) → 206 (2007) **Incidence** • 137 (2001) → 139 (2007) **Mortality** /3 • 32 (2001) → 26 (2007)

/1 Objectives synthesized from the Global Plan to Stop TB 2001–2005, Amsterdam Declaration, Washington Commitment, & Global Plan to Stop TB 2006–2015.
/2 The particularly low figure for case detection under DOTS in the European Region is explained by two factors: incomplete geographical coverage of DOTS and lack of emphasis on sputum smear microscopy. Countries in the European Region report substantial numbers of cases in whom disease is diagnosed by methods other than sputum smear microscopy. These cases are not necessarily smear negative.
/3 Figures include cases of HIV co-infection. All rates reported per 100,000 population.

Objectives [1]	Activities	Outputs	Outcomes
b. Improve procurement and distribution systems for TB drugs to ensure quality, access, and timely supply	**Global Drug Facility (created 2001)** • Grant-making • Direct Procurement • Quality Assurance • Technical Assistance to improve countries' ability to finance, procure and manage their drug supply	• Direct Procurement Service business generated to date: $25.7 million [4] • Applications (new and repeat) approved for support: 159 • Technical assistance visits organized by the GDF (pre-delivery, monitoring and DP missions): 172	**Treatments supplied** [5] 10,000(2001) → 2,113,000 (2006) (10 million cumulative treatments) **Grant procurement (2001–2007)** • 66 recipients; 8,577,615 treatments **Direct procurement (2001–2007)** • 43 countries; 2,574,464 treatments Limited impact on ensuring alternative funding Limited impact on improving national procurement mechanisms
c. Implement monitoring and evaluation systems for national TB programs in line with WHO standards	**DOTS Expansion Working Group** • Supports monitoring and evaluation through the expansion of DOTS globally by aligning and supporting country activities • Organizes annual meeting of NTP managers from HBCs to foster commitment and accountability • Works closely with WHO unit on M&E	M&E guidelines standardized (WHO function)	• 196 (out of 212) countries reported data to WHO in 2007, accounting for 99.6% of the world's estimated TB cases (most of the survey components were completed by the majority of countries) • Survey data reported on components of the Stop TB Strategy: DOTS expansion and enhancement; TB/HIV and MDR-TB; Health System strengthening; Engaging all care providers; Empowering people with TB, and communities; Enabling and promoting research

/4 Figures last updated on GDF Web site in 2006; http://stoptb.org/gdf/whatis/facts_and_figures.asp.
/5 The majority of HBCs did not experience central or peripheral stock-outs of first-line anti-TB drugs in 2007.

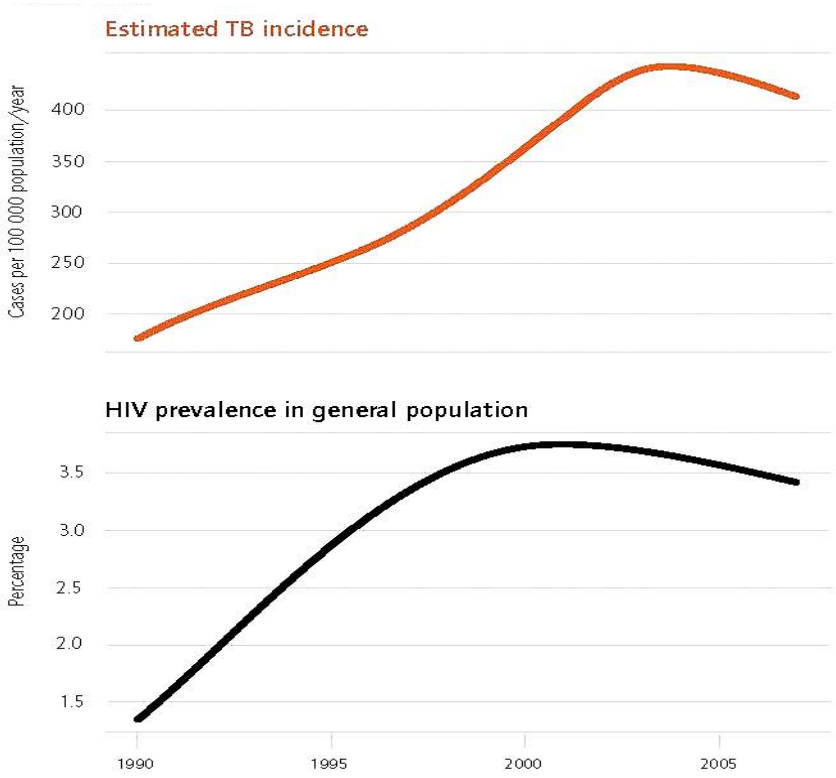
Objectives [1]	Activities	Outputs	Outcomes
2. Develop and scale-up effective responses to the emerging challenges of drug resistance and HIV-related TB: a. Adapt DOTS to prevent and manage MDR-TB, and to reduce the impact of HIV-related TB	• TB-HIV Working Group (created 2001) • Working Group on MDR-TB (initially created in 1999, renamed in 2006) • Technical and policy support to WHO and its members to prevent the spread of Multi Drug Resistance through the Green Light Committee	**Pilot projects:** • 51 projects in 40 countries for cross-testing and counseling	**Grants for GLC-approved second-line drugs (2007)** • 17 countries → 4,717 treatments • Treatments covering 5–10% of MDR cases worldwide
3. Improve and expand tools available for TB diagnosis, treatment and prevention: a. Accelerate basic and operational research for the development of new diagnostics, drugs and vaccines b. Promote adoption of new and improved tools by ensuring appropriate use, access and affordability	• Working Group on New TB Diagnostics • Working Group on New TB Drugs • Working Group on New TB Vaccines (all created 2001)	**Funding generated for development of new tools:** • $125 mil. (2001) → $1.048 billion (2007)	• 10 new drugs • 13 new diagnostics • 8 new vaccines in the pipeline or in clinical trials
4. Strengthen the overall global partnership to Stop TB so that proven TB-control strategies are effectively applied: a. Develop the second Global Plan to Stop TB for the period b. Promote the development of national and international partnerships to stop TB with all stakeholders in society	• Advocacy, Communication and Social Mobilization Working Group (created 2001, disbanded 2009) • Three meetings of the Partners' Forum (2001, 2004, 2009): Inclusive, consultative meetings of representatives of all Stop TB partners	• **Global Plan to Stop Tuberculosis 2006-2015** • Increased political visibility: Inclusion in two G8 summits • TB included in portfolio of Global Fund activities • Series of World Health Assembly (WHA) resolutions initiated and supported which anchor Stop TB objectives and operational targets as international obligations	**Increased number of partners:** • 7 (1998) → 40 (2001) → 900+ (2009)

3.11 Recent research indicates the Partnership's significant economic value. The World Bank report *Economic Benefit of Tuberculosis Control*, commissioned by the Stop TB Partnership, found that the economic benefits of sustaining the DOTS strategy significantly outweigh the costs for the 22 countries with the world's highest TB burden. The marginal benefits of implementing the Global Plan outstrip the marginal costs by a factor of nine for African countries, while nations outside of Africa could receive a 15-fold return on their investment in TB control.[20]

Efficacy

3.12 The major conclusion of the 2008 independent evaluation is that the Partnership has had a significant impact on TB control and research and should set "high aspirations" for future achievements. This appears to be a fair assessment. The Partnership has built a solid platform for expanded results and continued progress towards achievement of its objectives. The logframe below relates core objectives (synthesized from core Partnership objectives for the purposes of this GPR), activities, outputs and outcomes (Table 6).

Figure 4. Estimated Incidence of TB and Prevalence of HIV for the African Subregion Most Affected by HIB (Africa high HIV), 1990–2007



Source: Global Tuberculosis Control WHO Report 2009.

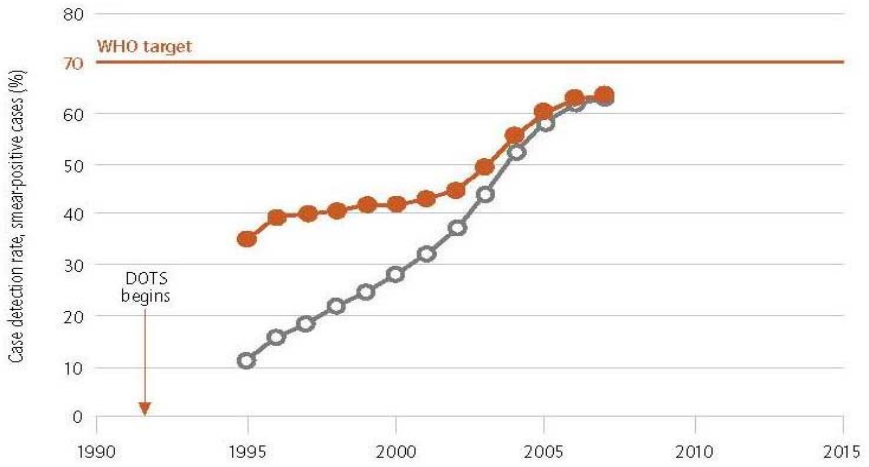
20. Laxminarayan, Ramanan, et al. *Economic Benefit of Tuberculosis Control* (Policy Research Working Paper 4295), Washington DC: The World Bank, 2007.

3.13 The expansion of the DOTS strategy is almost complete. A total of 187 countries now implement DOTS. The 22 High Burden Countries reported 98 percent of the population covered by DOTS in 2006, compared to 61 percent in 2001. Worldwide, TB prevalence has dropped from 262 to 206 per 100,000 persons and mortality from 32 to 26 per 100,000, but incidence remains stable.[21] The reductions are lower than expected at the inception of Stop TB, reflecting the dramatic increase in HIV-related TB cases and emerging drug resistance. The correlation between TB incidence and HIV prevalence in sub-Saharan Africa is dramatic (Figure 4). Case detection rates in countries have more than doubled since 2001 and are at 63 percent globally (2008), still shy of the 70 percent target (Figure 5).

3.14 The improvements in National Control Programs, which can be attributed largely to extensive advocacy as well as to technical support and provision of drugs by the Partnership, are shown in detail in Annex I in four HBCs — China, India, the Russian Federation and South Africa. The increases in DOTS coverage since 2001, as well as the dramatic increases in national budgets allocated for TB control, are remarkable after years of stagnation. The country examples also show the extent to which NTPs have improved their data reporting systems. This extraordinarily detailed level of data stands out among similar large-scale disease control programs. Despite the impressive monitoring, quality-controlled impact measurement remains an issue.

3.15 MDR-TB, driven by the HIV epidemic, has become a major issue for global tuberculosis control as discussed under "Relevance" above. The Partnership has highlighted this issue and devoted major resources to its resolution. Results to date have been moderate, however, predominantly due to the lack of rapid diagnostic techniques for MDR- and

Figure 5. Progress Toward the 70 Percent Case Detection Target



Open circles mark the number of new smear-positive cases notified under DOTS 1995–2007, expressed as a percentage of the estimated new cases in each year. Closed circles show the total number of smear-positive cases notified (DOTS and non-DOTS) as a percentage of estimated cases.
Source: Global Tuberculosis Control WHO Report 2009.

21. "Prevalence" refers to the number of cases of a disease in a defined population at a specified point in time, whereas "incidence" refers to the number of **new cases** of a disease arising in a given period in a specified population.

XDR-TB.[22] The Partnership recently created a Global Laboratory Initiative and requested donor assistance for strengthening laboratory systems in HBCs. While the Green Light Committee is highly regarded as a model for dealing with drug resistance, estimates are that it presently covers only about 5–10 percent of all MDR and XDR cases due to the difficulties of detection.

3.16 It is widely recognized that tuberculosis cannot successfully be controlled or eliminated with the present tools. The Partnership has been very successful in making this point internationally and attracting resources; collateral commitments to research for development of new drugs, diagnostics and vaccines reached $1 billion in 2007. There are now several new drugs, diagnostics and vaccines in the pipeline or in clinical trials.

3.17 The Partnership has significantly increased the political visibility of tuberculosis on the global scale. It has been instrumental in the inclusion of TB in the portfolio of Global Fund activities as well as on the agenda of two G8 summits. Additionally, the Partnership's objectives and activities have systematically been formalized as internationally-applicable through a series of World Health Assembly Resolutions.

3.18 Furthermore, the Partnership has increased its number of Partners from 40 in 2001 to over 600 presently. While this represents significant progress, it also poses the significant challenge of managing such a high volume of Partners. The External Evaluation responded to this in proposing that Stop TB publish a full Global Plan progress report every three years, prior to the Partners' Forum, and focus the Forum on discussing this report.

3.19 Objectives stated in core Partnership documents and confirmed by WHA Resolutions[23] have been appropriately adjusted and expanded over time in the context of the changing reality of the TB landscape. However, a unified set of objectives would provide an evaluative framework for the Partnership and significantly enhance performance transparency (a recommendation of the 2008 McKinsey evaluation).

3.20 The 2008 Evaluation focuses on *why* the Partnership has been effective. IEG considers this process-oriented approach to be extremely valuable. The Stop TB Partnership works through inclusive, collaborative forums and engages the expertise of various constituencies in the collective effort, while focusing on filling gaps in areas such as global advocacy and improving access to high quality drugs. Agreement to work in partnership and to give each Partner a voice — i.e., to work cooperatively towards a common goal, without renouncing the independence and individual mandates and priorities of its Partners — is the guiding principle on which the Partnership operates. By facilitating this continuous dialogue, it adds value to what could have been accomplished in its absence; this feature is widely recognized as a central "signature" of the Partnership and was emphasized in interviews undertaken for this review.

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22. The diagnosis of MDR- and XDR-TB requires highly-developed laboratory capacity and takes on average 2–3 weeks before results are available. Therefore, many resistant cases go undetected by NTPs, creating conditions for further spread of resistance.

23. Core documents outlined in detail in *Annex X: Core Partnership Documents & WHA Resolutions.*

3.21 The Partnership is widely recognized as the most legitimate forum for discussion of tuberculosis control policies, strategies and technical issues. Given the diversity of Partners, including those with a long history of interest in tuberculosis control (e.g., the Union and others), the Partnership, with its shared goals and legitimate processes, is considered the "glue" holding together the "community" involved in tuberculosis control. For example, Working Groups, representing a diverse range of interests (including the private sector), have a high degree of independence yet are the foundation of Partnership operations. Also, due to the close collaboration between the Partnership and WHO, it provides input and endorsement to the normative guidance of WHO and others but does not issue its own.

3.22 In June 2006, WHO established a Global Task Force on TB Impact Measurement to measure progress towards the 2015 global targets.[24] The Task Force includes experts in TB epidemiology, representatives from major technical and financial agencies and representatives from high-burden countries, with a mandate to produce a rigorous assessment of progress towards achievement of targets for TB incidence, prevalence and mortality globally as well as for each WHO region and individual countries. To date, Stop TB has not reported extensive epidemiological data, and, in line with recommendations from the 2008 Evaluation, it should seek to accelerate progress in the area of impact measurement. TB epidemiology and control metrics should further be developed and utilized, specifically in areas such as TB-HIV, MDR-TB, and pediatric TB.

3.23 The Task Force is expected to report regularly on progress towards targets in the years leading up to 2015, and to strengthen national capacity in monitoring and evaluation of TB control. Following three Task Force meetings (June 2006, December 2007 and September 2008) and two years of work by the secretariat and WHO, a set of policies and recommendations were agreed upon for measuring incidence, prevalence and mortality from 2008 onwards, focusing on the 2015 impact targets. These recommendations are summarized in the form of a policy package (Box 1) and will be detailed fully in a forthcoming policy paper, *Measuring progress in TB control: WHO policy and recommendations.*[25] Field testing of a standard framework and tool for systematic assessment of surveillance data, implementation of prevalence surveys in at least 3 of the 21 global focus countries and a review and update of current TB estimates are planned for 2009.[26]

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24. Stop TB Partnership, *Summary Sheet on the Global Task Force on TB Impact Measurement*, 15th Stop TB Partnership Coordinating Board Meeting: Bagamoyo, Tanzania, 2008.

25. World Health Organization, *Global Tuberculosis Control 2009*, citing *Measuring Progress in TB Control: WHO Policy and Recommendations* [policy paper], Geneva, World Health Organization, 2009 (in press). The policy paper is based on (i) a comprehensive review of methods to measure incidence, prevalence and mortality (Dye C et al. Measuring tuberculosis burden, trends and the impact of control programmes. *Lancet Infectious Diseases*; published online 16 January 2008 (available at http://infection.thelancet.com) and (ii) background papers prepared for Task Force meetings and associated discussions. The policy paper was endorsed by the Task Force during its meeting in September 2009. It was also reviewed by WHO's Strategic and Technical Advisory Group on TB (STAG-TB) in June 2009.

26. Stop TB Partnership, *Summary Sheet on the Global Task Force on TB Impact Measurement*, 15th Stop TB Partnership Coordinating Board Meeting: Bagamoyo, Tanzania, 2008.

Box 1. WHO Policy Package for Measuring Rates of TB Incidence, Prevalence, and Mortality, 2009–2015 and Beyond

General

1. Improve surveillance systems to include all (or almost all) incident cases in TB case notification data and to account for all (or almost all) TB deaths in vital registration systems
2. Strengthen national capacity to monitor and evaluate the TB epidemic and to measure progress in TB control
3. Review and update periodically the data, assumptions and analytical methods used to produce WHO estimates of TB incidence, prevalence and mortality rates
4. Report by Task Force on whether 2015 MDG and Stop TB Partnership targets are achieved (or not), shortly after 2015

Measuring TB incidence rates

1. Analyze periodically the reliability and coverage of case notification data using a standard framework, in order to estimate the total number of incident TB cases and trends in incidence rates
2. Certify and/or validate TB notification data for countries where analyses using the standard framework show that TB notification data are a close proxy (direct measure) of TB incidence
3. Cross-validate estimates of TB incidence using TB mortality data from vital registration systems

Measuring TB prevalence rates

1. Survey the prevalence of TB disease in 21 global focus countries according to WHO guidelines and Task Force recommendations
2. Produce indirect estimates of TB prevalence based on estimates of TB incidence and duration of TB disease for countries where surveys of the prevalence of TB disease are not implemented

Measuring TB mortality rates

1. Develop national vital registration systems to reliably record all TB deaths
2. Initiate sample vital registration where national vital registration systems are not yet available
3. Produce indirect estimates of TB mortality using estimates of TB incidence and case fatality rates for countries without reliable national or sample vital registration systems

Evaluating the impact of TB control

1. Conduct studies periodically to evaluate the impact of control on rates of TB incidence, prevalence and mortality

Source: World Health Organization, Global Tuberculosis Control 2009, citing Measuring Progress in TB Control: WHO Policy and Recommendations [policy paper], Geneva, World Health Organization, 2009 (in press).

Efficiency and Cost-Effectiveness

3.24 The linkage created by housing both the Partnership Secretariat and the Stop TB Department at WHO has generated an organizational mechanism that is instrumental in the program's achievements as a whole. The division of labor in technical areas (i.e., certain working groups housed under the WHO Department and others, such as vaccines and diagnostics, operated more appropriately by the Secretariat) delegates responsibilities to the most appropriate entity. Importantly, administrative and financial operations are undertaken by a joint unit serving both the Partnership Secretariat and WHO's Stop TB Department. This special "host" relationship facilitates day-to-day operations and lowers transactional costs.

3.25 The Partnership systematically analyzes and categorizes program costs in each of its annual reports. Secretariat expenditures are delineated by program costs for the Partnership,

advocacy and communication, and the GDF, as well as by overhead costs for general management and administration. Costs for the Global Drug Facility are further broken down according to grant procurement; direct procurements; quality assurance and pre-qualification; technical assistance, monitoring and salaries; and advocacy and communication.

3.26 The administrative costs of the Stop TB Partnership Secretariat have averaged 17 percent, which includes some administrative costs for GDF operations. In addition, a 3 percent service charge has been paid to WHO for drug procurement. This compares to 14 percent for GAVI (which is a financing facility) and 34 percent for UNAIDS, as indicated by the external evaluation.

3.27 Channeling development assistance through the Stop TB Partnership has decreased transactional costs, particularly for drugs, compared with traditional development assistance programs both for donors and beneficiary countries. The Partnership harmonizes donor efforts and consolidates disbursements such as through the GDF pooled procurement mechanism. Partnership efforts also harmonize monitoring and evaluation, as evidenced by the comprehensive annual global TB control reports compiled and disseminated by WHO. This has proved beneficial for all stakeholders.

Governance and Management

3.28 The governance structure, established in 2001 and modified in 2003, encourages collaboration and cooperation without attempting to direct or control individual partners. Any party supporting the values and principles of the Partnership can have a voice in Stop TB. The Partnership provides a range of forums for collaboration, in particular the inclusive and consultative Partners Forum. This Forum is a highly visible platform for partner representatives to share achievements and challenges, endorse common strategies and consolidate commitment for the implementation of the Stop TB Strategy and Global Plan.

3.29 Responsibilities, such as providing technical assistance and participating in Working Groups, are appropriately distributed among partners based on institutional expertise and intended contribution to Stop TB. When completing the online Partner Application Form, prospective partners indicate the activities in which they are currently involved (selecting from specific activities under the categories of advocacy, communication, and social mobilization; funding; manufacture of TB products; research; TB health care services; and technical assistance) as well as their motivation for joining Stop TB (information on developments within the TB world; involvement in Stop TB Working Groups; network with other partners; resource mobilization; technical assistance and advice; other). Partners are able to join Working Groups through various mechanisms, such as completing an online application form and/or contacting the Working Group chairperson or core group/secretariat. Partners are also invited to Working Group meetings in accordance with their area of work.

3.30 The Partnership’s accountability mechanisms are largely appropriate. The Partnership is subject to the internal and external audit procedures of WHO, as it is located and administrated by WHO’s Stop TB Department. The Secretariat is accountable to the Coordinating Board, with the Executive Secretary of the Stop TB Partnership Secretariat serving as Secretary of the Board (potential conflicts of interest do not seem to be an issue).

The Coordinating Board provides leadership and direction for the Partnership. It is accountable to the Partners' Forum and comprehensively reports and responds to Partners not directly involved in the governance of the program and not part of its direct chain of accountability at each meeting of the Forum. The Board serves as an active information channel to its constituencies. For example, representatives from affected communities open an online exchange prior to each meeting to show support, gather feedback and act on behalf of the community. After each meeting, the Board shares full meeting reports with all partners and the general public through postings on the well-organized and highly informative Stop TB Web site.

3.31 While overall Partnership accountability mechanisms seem generally appropriate and transparent, the latest evaluation identified specific areas for improvement. In particular, Stop TB should improve "performance transparency" related to the impact and efficiency of the Working Groups. The 2008 Evaluation stressed the need to systematize processes for their establishment and performance review. It recommended that Working Groups be formed for a fixed duration of 3 years, reviewed every 3 years by the Coordinating Board and created and disbanded in response to their performance and changing areas of need. Accountability of Working Groups could also be improved, as pointed out by the independent evaluation. Some Working Groups lack adequately defined metrics for outputs, targets or performance review mechanisms, and need to improve the tracking of resource commitments and use of funds for their work.

3.32 The DOTS Expansion Working Group, however, is stronger in its accountability mechanisms. It has established a system for recipient countries to report regularly on basic metrics and epidemiological indicators. Country program managers representing high-burden countries meet at least once a year and report on progress in the presence of peers and major donors. This publicly exerted peer pressure facilitates accountability and holds countries responsible to their commitments.

3.33 The Stop TB Partnership is a counter-example to a perception expressed in the literature that a "UN organization hosting global programs" generates conflicts of interest and adversely affects governance, management, transparency, or fairness. WHO plays a significant role in the program but not at the expense of efficient partner participation. Housing Stop TB at WHO works well and has increased efficiency. It enhances Partnership accountability and fairness, and is proving beneficial to effective and efficient participation by all those active in the Partnership. Partners benefit from the strength of WHO's Stop TB Department, as well as its normative guidance and credibility at the regional and country level.

Resource Mobilization

3.34 In an effort to mobilize resources in a systematic manner and bring in new donors, the Stop TB Secretariat established a Task Force on Resource Mobilization in 2004. The Task Force commissioned a survey of existing and potential multi- and bilateral development agencies to obtain data on recent and projected TB expenditures for the period 1999–2004.

The donor survey,[27] undertaken jointly by the Partnership Secretariat and the HLSP Institute (formerly IHSD), reported a steady increase in funding available for TB from 1999 to 2004 and highlighted the substantial and growing significance of the Global Fund. While results indicated increasing geographical spread of funding, there did not appear to be significant diversification of donors. The majority of funding allocated to TB control activities (69 percent) was from bilateral donors, 21 percent from multilateral agencies (World Bank), and 10 percent from Foundations. The US, Canada, and UK accounted for the majority of funding from bilateral donors. Since the survey, CIDA, USAID, and the government of the Netherlands have remained consistent major donors, with new donor commitments from the Nordic countries, Japan and Germany

3.35 As is common in global programs, earmarking of donor funds is common in Stop TB and is an issue. Only limited funding is undesignated to be allocated as determined by the Partnership.

3.36 The Partnership's operational budget has increased dramatically from $2.5 million in 2001 to $14.4 million in 2008. Income for GDF has increased from $15.2 million in 2001 to $78.8 million in 2008. Annex I shows development of funding for selected High Burden Countries.

3.37 The Partnership has been very successful in mobilizing "parallel" resources for development of new tools for TB control by highly profiling the research agenda, in particular to donors such as Gates. Overall research funding for new drugs, diagnostics and vaccines increased from US$125 million in 2000 to $750 million in 2006, and there are now ten drugs, seven vaccines and 13 new diagnostics in the pipeline or in clinical trials as a result.[28]

3.38 The Bill and Melinda Gates Foundation is a major source of this increased funding for drug research and diagnostic and vaccine development. In September 2007, the Gates Foundation announced additional grants totaling $280 million ($200 million to Aeras Global TB Vaccine Foundation for clinical trials of vaccine candidates, $62 million to FIND to develop simpler and more accurate diagnostics, and $18 million for new treatments to combat drug resistance),[29] responding to the large amount requested for new tools in the Global Plan. In this sense, the Partnership has been effective in attracting collateral funding.

Sustainability, Risk, and Strategy for Devolution or Exit

3.39 The sustainability of the outcomes of the Partnership's activities depends not only on the sustainability of the Partnership itself, but also on its ability to adapt to a changing world,

27. Stop TB Partnership & HLSP Institute, *Trends in International Funding for TB Control*, Resource Mobilization Task Force of the Stop TB Partnership, 2005.

28. *The Lancet*, Infectious Disease Commentary, Evaluating a Global Health Guardian, Vol. 8, July 2008, http://infection.thelancet.com.

29. Bill and Melinda Gates Foundation, New Grants to Fight Tuberculosis Epidemic: 11 New Grants Will Speed Development of TB Vaccines, Diagnostic Tests, and Drugs in Support of the Global Plan to Stop TB, Seattle, 2007.

the complementary activities of its donor partners, and on the capacity of high-burden countries to sustain tuberculosis control.

3.40 The Stop TB Partnership is currently envisioned to have a long life. According to the *Basic Framework of the Global Partnership to Stop TB*, "the Stop TB Partnership will exist as long as needed,"[30] with the Board able to dissolve the Partnership at its discretion. Although it benefits from external financing, the idea for the Partnership is not time or resource-limited, and is constructed with a flexibility that will allow it to withstand changing market and environmental conditions. While in the short run the need for the Partnership is unquestionable, criteria for devolving activities and a potential exit strategy require definition.

3.41 The Partnership exists as a loose, "living" body that seeks to adapt to a continually changing landscape. Its structural components (Partnership bodies) were created not as fixed entities, but rather as responsive and relevant initiatives to meet felt needs. As indicated in its operating principles, the founding vision of the Global Drug Facility was a time-limited body with an expected life of 10–15 years.[31] The GDF has created a market for TB drugs with transparent and competitive procurement, but ultimately seeks to identify strategies for gradually transferring drug procurement back to participating nations. Working Groups were originally conceived as loose associations based on voluntary commitments and flexible, short-term appointments and were expected to continue only as needed. This feature has continued, but needs to be further reviewed, thus assuring that adaptability will remain the key to the program's achievements and sustainability.

3.42 At the country level, Partners provide resources that are additional to existing national program activities in order to ensure that countries do not become dependent on external resource flows. Country ownership, in terms of both financial and political commitment, is central to Partnership activities. GDF provides grants for anti-TB drugs with the goal that the country will develop the ability and funding to utilize direct procurement, and will move through the "step-ladder" of GDF services and gradually become self-sustaining [exit strategy].

3.43 The Partnership also supports countries in sustaining tuberculosis control through technical assistance and capacity building. TBTEAM, a technical assistance mechanism created by Stop TB partners in 2007, works to: (a) facilitate access to high-quality technical assistance; (b) encourage planning at national, regional and global level, but most importantly at national level; (c) improve the efficiency of TA by ensuring that needs are met while minimizing redundant TA; (d) promote capacity-building at all levels in terms of TA planning and training of consultants according to international standards. Where a National Partnership or similar collaborative entity exists, National TBTEAM functions as a mechanism for TA coordination among these partners. The involvement of all stakeholders in project planning and evaluation, as well as the development of plans for phasing out external assistance, seeks to ensure that countries will eventually take over some of the current responsibilities of various Partners so that the larger Stop TB Partnership is able to devote its attention to areas of greatest need.

30. Stop TB Partnership, *Basic Framework for the Global Partnership to Stop TB*, 2004.

31. Stop TB Partnership, *Operating Principles of GDF*, 2009.

4. World Bank's Performance in the Partnership

4.1 The World Bank supports tuberculosis control on many levels and in different ways. Globally, it has contributed to the Stop TB Partnership trust fund through Window One of its DGF facility; at the country level, it has provided financial support through lending operations. In addition, the Bank exercised its convening power at the formative stages of the Partnership and remains a permanent member of the Coordinating Board. Until the creation of the Global Fund to Fight AIDS, Tuberculosis, and Malaria, the Bank was the largest provider of resources for TB control, and influenced the direction of TB control jointly with WHO. In 1995, the Bank seconded a staff member to the WHO TB Unit. Subsequently, WHO seconded a staff member to the Bank, and is presently financing a TB specialist position at the Bank. These arrangements have been well-received and beneficial.

4.2 The Bank has played an important role in setting up the institutional framework of the Stop TB Partnership. As a founding member of the Partnership, the Bank used its institutional leverage and convening power to good effect. The invitation to the first Stop TB Partners' Forum in Washington DC was jointly signed by Bank President Wolfensohn and WHO Director-General Brundtland, both of whom helped launch the Partnership. For the following two Partners' Forums (in New Delhi and Rio de Janeiro) the Bank, in addition to its delegation, assisted the Partnership with an experienced staff member as moderator. Initially, Director-level staff represented the Bank at Board meetings. More recently, senior technical-level staff have represented the Bank, which has seemingly prompted other players to perceive the Bank as less interested.

4.3 Financially, the Bank has supported the Partnership since its inception with an annual grant through Window One of its DGF facility. The grant amount of $700,000 has been constant. The annual DGF funding is undesignated. In addition, the Bank temporarily administered a Stop TB Trust Fund on behalf of the Partnership. This trust fund was simply a "fiscal agent" trust fund to accommodate some donor preferences, particularly Canada's for channeling their support through the Bank, and which accumulated disbursements of US$19.5 million from 2002 until its closure in June 2006.

4.4 The Human Development Network, which sponsors the DGF grant and represents the Bank at the Coordinating Board, has allocated funding for oversight and liaison activities. Yearly budget allocations have been at the low side and decreasing in the past years (Table 7).

4.5 Today, the Partnership views the Bank primarily and unsurprisingly as a major source of funding for national control programs, as evidenced by the secondment of a WHO/Stop TB staff member to the Bank. This view is further based on the track record of major investment lending for TB in Asia, Eastern Europe and Latin America in the last two decades, which is reviewed in detail in Annex J**.** Large investment operations in China, India and Russia are recognized as having been instrumental in establishing DOTS in these countries. However, there has been very limited TB-specific funding in the Africa portfolio — in contrast to the major investments in TB control in Asia and the former Soviet Union. There has, though, recently been a renewed interest in TB control in the Africa region.

Table 7. HDNHE Administrative Budget Expenditures on Oversight and Liaison Activities in Relation to the Stop TB Partnership

Allocations to the Stop TB Partnership				
Fiscal Year	**Labor**	**Travel**	**Other**	**Total Cost**
2005	54,938	24,286	790	80,013
2006	40,708	11,436	237	52,380
2007	21,564	8,002	146	29,712
2008	20,188	11,636	90	31,914
2009	11,590	22,367	99	34,056
Total	148,988	77,726	1,361	228,075

Source: Downloaded from SAP, the Bank's Management Information System, on June 17, 2009.

4.6 The lack of attention to TB in the Bank's Africa health portfolio has not gone unnoticed. Civil society groups have pointed out this gap — with reports and with critical public statements.[32] This was followed in 2007/08 by a "pre-printed postcard campaign" addressed to World Bank President Zoellick urging the Bank to pay more attention to TB in Africa. In response to the external criticism, Bank management in the Africa region has pointed to the relatively small size of countries, which makes single-disease projects difficult due to their high preparation and implementation costs, and the limited IDA funding available for health sector operations. However, diseases such as HIV and malaria are treated as categorical programs in the Bank's Africa portfolio, in contrast to TB control.

4.7 Some misunderstandings between the Bank and the Partnership have occurred around a recent study on the economics of TB. The study was requested in 2005 by the Stop TB Board, and was executed by the Bank with funding from the Bill & Melinda Gates Foundation. Its preparation took almost two years before preliminary results were presented. The final report was published in November 2007. The study's unusually long preparatory process was met with disappointment by the other Partners who had high expectations for this study, which had been assigned to the Bank because of its reputation both for economic expertise and a commitment to TB control. Consequently, for almost two years, the report was not circulated as widely as the Partnership would have expected. However, the substantive report has now been made widely available and was positively received and featured during the recent Partners Forum in Rio.

4.8 An as yet unresolved issue is countries' inability to use IDA funding for the procurement of anti-TB drugs through the Global Drug Facility (GDF), as such procurement has not been deemed to be in accordance with Bank procurement guidelines. In response, in January 2008 the World Bank's Africa Region undertook a study of the GDF procurement system in collaboration with GDF and financed by the Government of the Netherlands. The report, which was completed in January 2008, reinforces the view of inconsistencies between the WHO/GDF and the Bank's procurement regulations. The major issues are the use of a procurement agent (presently GTZ) by GDF and the inadequate number of WHO prequalified products and pharmaceutical manufacturers (WHO prequalification

32. RESULTS International, *Enduring Neglect: The World Bank's Inadequate Support for Africa's TB Emergency,* Washington DC, 2006.

requirements—substantially different from World Bank prequalification—are extensive, requiring on site inspection and resulting in a large backlog of applications). While discussions are still ongoing, the procurement of Bank-financed anti-TB drugs must be undertaken via mechanisms other than the GDF (except in emergency situations where the Bank issues a waiver). This situation has been met with surprise by other Stop TB Partners, who hold the view that the GDF is the best mechanism for low-cost and efficient quality-drug procurement for TB. A speedy resolution or clarification of these issues would be in the Bank's reputational interest as well as the countries' interest.

5. Lessons

5.1 The Stop TB Partnership is widely regarded as one of the best performing global partnerships in the health sector. IEG confirms this finding based on an analysis of documents, interviews conducted for this review, and the recent external evaluation of the Partnership undertaken in 2008.

5.2 The experience with the Stop TB Partnership offers a number of lessons for the partnership, for other global health programs, and for the World Bank's engagement in global partnership programs more generally.

For Stop TB and Other Global Health Partnerships

5.3 First, both a clearly "operationalized" control strategy (such as the Global Plans to Stop TB, 2001–2005 and 2006–2105) and broad consensus among partners on the technical features of that strategy have been key drivers of its achievements, since infectious disease control programs are to a large extent technology-dependent. Formulation of broad objectives must be accompanied by a clear and widely accepted operational strategy.

5.4 Second, the Partnership is characterized by responsiveness and participation — or as the external evaluation calls it, an "inclusive, collaborative approach". There have been three key elements of this approach:

(1) The Partnership has actively encouraged constituencies involved in TB to join the collective effort and has provided a "forum for collaboration".
(2) Partner organizations have retained full autonomy over their respective contributions; the Partnership has focused on reaching agreements on operational objectives and strategies and avoided a controlling or interfering attitude.
(3) The Partnership has developed and institutionalized a "collaboration culture"; making decisions on the basis of consensus has been a deliberate institutional approach from the beginning of the Partnership.

5.5 Third, despite their diversity, there is a shared understanding of the respective roles, responsibilities and commitments of Partners, including the long-established players such as the Union. Partners contribute in light of their respective comparative advantage. At the country level, the "TBTEAM mechanism" is an example of how individual partners are independently providing specific technical support to programs on behalf of the Partnership.

5.6 Fourth, innovation is another feature of the Stop TB approach. New and important Partnership bodies have been created in response to pressing needs — the GLC and GDF being prime examples of this. Both are innovative mechanisms, not just for TB control, but in the broader public health field. They deal with the critical area of TB drug resistance and maintaining the flow of anti-tuberculosis drugs, thus ensuring uninterrupted treatment programs. Furthermore, the terms DOTS, “Stop TB” and the Green Light Committee (GLC) now enjoy general “brand recognition”, further legitimizing the activities of the Partnership.

5.7 Fifth, the Program has demonstrated the flexibility to “dissolve” an institutional entity when no longer needed. The recent disestablishment of the Working Group on Advocacy recommended by the external evaluation is an example of this. Despite differences of opinions among Board members, the Coordinating Board was able to arrive at a consensus to terminate the Working Group as other parts of the Partnership had taken on advocacy functions.

5.8 Sixth, the Partnership has built a special relationship with its host organization and lead partner, WHO. Because the roles and responsibilities of the Secretariat and the WHO Department have been clearly defined, professional cooperation has been intense and transactions costs have been low due to the physical closeness of professional staff. Furthermore, although WHO has the technical and institutional mandate to issue normative directives in the health sector, it also benefits as the host partner from extensive discussions with the Secretariat and its external Partners. As a result technical guidance has largely been issued consensually despite the independence and diversity of Partners.

5.9 Seventh, the working relationship and communication between the Partnership’s Secretariat and WHO’s Stop TB Department have been excellent. Recently, administrative support for both entities has been combined so as to reduce transactions costs and increase efficiency. This has avoided the institutional wrangling over control and resources that has occurred in some other host-agency arrangements.

5.10 Eighth, the Stop TB Partnership has developed and capitalized on its political “know how” to make its global efforts widely visible (G8 and the Global Fund). It has addressed both the technical issues and the socio-political forces that must inevitably be harnessed for achieving dramatic and lasting improvements in the health status of poor and marginalized segments of the population, as is the case for those suffering from TB in developing countries.

For the World Bank

5.11 The Bank has been a major institutional player in the Stop TB Partnership. It has acquired institutional legitimacy and a positive reputation due to its effective engagement with other Partners during the creation of the Partnership and due to its country-level operations on control of tuberculosis and other infectious diseases. However, such a positive reputation needs to be actively maintained.

5.12 When the Bank engages in a global partnership program as important as Stop TB, it is viewed by outsiders as a single institutional player and not as a “federation of Regions”.

Differences in approach to development assistance across the Bank's Regions — such as the lower level of attention to TB control projects in the Africa Region — need to be explicitly addressed and explained at the institutional level to avoid damaging the Bank's reputation among other stakeholders who view the Bank as having a comparative advantage in addressing health issues in Africa.

5.13 Client countries' persistent inability to use World Bank funds to procure drugs through the Global Drug Facility has been cited as an example of sometimes-complicated internal Bank processes. External observers have not easily understood why the Bank cannot use the vehicle of the GDF — which was created with the sole purpose of assuring an efficient, low-cost, steady supply of TB drugs. The legitimate differences in procurement procedures between the GDF and the World Bank need to be conclusively dealt with. Delegating the differences to the category of a "can wait" and dealing with them over a protracted period of time risks reflecting negatively on the institutional reputation of the Bank.

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Annex A. Evaluation Framework for Global Program Reviews

Note: This evaluation framework is a general framework that has been designed to cover the wide range of such programs in which the World Bank is involved, encompassing policy and knowledge networks, technical assistance programs, and investment programs. It is not expected that every global program review will cover every question in this table in detail.

Annex Table 1. Assessing the Independence and Quality of the Evaluation

Evaluation Questions
1. Evaluation process To what extent was the GRPP evaluation independent of the management of the program, according to the following criteria: • Organizational independence? • Behavioral independence and protection from interference? • Avoidance of conflicts of interest? Factors to take into account in answering these questions include: • Who commissioned and managed the evaluation? • Who approved the terms of reference and selected the evaluation team? • To whom the evaluation team reported, and how the evaluation was reviewed? • Any other factors that hindered the independence of the evaluation such as an inadequate budget, or restrictions on access to information, travel, sampling, etc.?
2. Monitoring and evaluation framework of the program To what extent was the evaluation based on an effective M&E framework of the program with: • Clear and coherent objectives and strategies that give focus and direction to the program? • An expected results chain or logical framework? • Measurable indicators that meet the monitoring and reporting needs of the governing body and management of the program? • Systematic and regular processes for collecting and managing data?
3. Evaluation approach and scope To what extent was the evaluation objectives-based and evidence-based? To what extent did the evaluation use a results-based framework — constructed either by the program or by the evaluators? To what extent did the evaluation address: • Relevance • Efficacy • Efficiency or cost-effectiveness • Governance and management • Resource mobilization and financial management • Sustainability, risk, and strategy for devolution or exit
4. Evaluation instruments To what extent did the evaluation utilize the following instruments: • Desk and document review • Literature review • Site visits and for what purpose: for interviewing implementers/beneficiaries, or for observing activities being implemented or completed • Case studies • Consultations/interviews and with whom • Structured surveys and of whom • Other

Evaluation Questions
5. Evaluation feedback To what extent have the findings of the evaluation been reflected in: • The objectives, strategies, design, or scale of the program? • The governance, management, and financing of the program? • The monitoring and evaluation framework of the program?

Annex Table 2. Providing an Independent Opinion on the Effectiveness of the Program

Every review is expected to cover the first four criteria in the following table: (a) relevance, (b) efficacy, (c) efficiency, and (d) governance and management. A review may also cover (e) resource mobilization and financial management and (f) sustainability, risk, and strategies for devolution or exit if the latter are important issues for the program at the time of GPR, and if there is sufficient information available on which to base an independent opinion.

Evaluation Criteria and Questions
Relevance: The extent to which the objectives and design of the program are consistent with (a) current global/regional challenges and concerns in a particular development sector and (b) the needs and priorities of beneficiary countries and groups.
1. Supply-side relevance — the existence of an international consensus that global/regional collective action is required. To what extent does the program reflect an international consensus on the need for action, on the definition of the problem being addressed, on priorities, and on strategies for action? Is the original consensus that led to the creation of the program still present? Is the program still needed to address specific global/regional public concerns? Take into account the origin of the program in answering these questions: • Is the program formally responsible for implementing an international convention? • Did the program arise out of an international conference? • Is the program facilitating the implementation of formal standards and approaches? • Is the program primarily donor-driven? Did donors establish the program with little consultation with developing countries? • Is the program primarily Bank-driven? Did the World Bank found the program and then seek other partners?
2. Demand-side relevance — alignment with beneficiary needs, priorities, and strategies. To what extent are the objectives consistent with the needs, priorities, and strategies of beneficiary countries as articulated in the countries' own PRSPs, and in donors' strategies such as the World Bank CASs, and the UN Development Assistance Frameworks? To what extent has the voice of developing and transition countries been expressed in the international consensus underlying the program?
3. Vertical relevance — consistency with the subsidiarity principle. To what extent are the activities of the program being carried out at the most appropriate level — global, regional, national, or local — in terms of efficiency and responsiveness to the needs of beneficiaries? To what extent are the activities of the program competing with or substituting for activities that individual donors or countries could do more efficiently by themselves? Pay particular attention to those programs that, on the face of it, are primarily supporting the provision of national or local public goods.

Evaluation Criteria and Questions
4. Horizontal relevance — the absence of alternative sources of supply. What is the comparative advantage, value added, or core competency of the program relative to other GRPPs with similar or complementary objectives? To what extent is the program providing additional funding, advocacy, or technical capacity that is otherwise unavailable to meet the program's objectives? To what extent are the good and services being provided by the program in the nature of public goods? Are there alternative ways of providing these goods and services, such as by the private sector under regular market conditions?
5. Relevance of the design of the program To what extent are the strategies and priority activities of the program appropriate for achieving its objectives? What are the major activities of the program: • Policy and knowledge networking? • Financing country and local-level technical assistance? • Financing investments to deliver national, regional, or global public goods? (See Annex Table 4.) Has the program articulated an expected results chain or logical framework, along with assumptions that relate the progress of activities with the achievement of the objectives? Does the results chain identify the extent to which the achievement of the objectives depends on the effective functioning of bureaucracies, markets, or collectivities? If so, to what extent are these assumptions valid? For programs providing global or regional public goods, is the design of the program consistent with the way in which the individual efforts of the partners contribute to the collective outcome for the program as a whole — whether "best shot", "summation", or "weakest link?"
Efficacy: The extent to which the program has achieved, or is expected to achieve, its objectives, taking into account their relative importance.
6. Achievement of objectives To what extent have the stated objectives of the program been achieved, or has satisfactory progress been made towards achieving these objectives? To what extent are there implicit objectives that are well understood and agreed upon by the partners and to which the program should also be held accountable? To what extent are there any positive, unintended outcomes of the program that have been convincingly document? To what extent have these assessments by the program or the evaluation been evidence-based?
7. Progress of activities, outputs, and outcomes. To what extent has the program or the evaluation measured the progress of activities, outputs, and outcomes? How did the program or the evaluation aggregate its outputs and outcomes at all levels — global, regional, national, and local — to provide an overall summary of its results? To what extent have factors such as changes in the location of the program, its legal structure, or governance processes affected the outputs and outcomes of the program? To what extent have there been outcomes that can be uniquely attributed to the partnership itself — such as the scale of or joint activities made possible by its organizational setup as a GRPP, or its institutional linkages to a host organization?
8. Linkages to country or local-level activities. To what extent has the program established effective operational linkages with country-level activities, taking into account that: • The desired nature of these linkages will vary according to the objectives, design, and implementation of each program? • Positive outcomes at the country or local level are generally a joint product of both global/regional and county-level activities?

Evaluation Criteria and Questions
Efficiency or cost-effectiveness: Efficiency — the extent to which the program has converted or is expected to convert its resources/inputs (such as funds, expertise, time, etc.) economically into results. Cost-effectiveness — the extent to which the program has achieved or is expected to achieve its results at a lower cost compared with alternatives.
9. Efficiency To what extent is it possible to place a monetary value on the benefits arising from the activities of the program? To what extent has the program or the evaluation conducted impact evaluations of representative program activities? To what extent has the program or the evaluation analyzed the program's costs in broad categories (such as overhead vs. activity costs), and categorized the program's activities and associated benefits, even if these cannot be valued in monetary terms?
10. Cost-effectiveness To what extent is the program measuring up against its own business plans: • Has the program cost more or less than planned? How did it measure up against its own costing schedule? • Have there been any obvious cases of inefficiency or wasted resources? To what extent is the program delivering its activities cost-effectively in comparison with alternatives: • How do actual costs compare with benchmarks from similar programs or activities? • Are the overhead costs of governing and managing the program reasonable and appropriate in relation to the objectives and activities of the program? How does the program compare with traditional development assistance programs: • For beneficiary countries, has receiving the development assistance through the GRPP increased the transactions costs compared with traditional development assistance programs? • For donors, has delivering the development assistance through the GRPP reduced donor costs by harmonizing efforts among donors or by reducing overlapping work (such as through joint supervision, monitoring and evaluation)?
Governance and management: Governance — the structures, functions, processes, and organizational traditions that have been put in place within the context of a program's authorizing environment to ensure that the program is run in such a way that it achieves its objectives in an effective and transparent manner. Management — the day-to-day operation of the program within the context of the strategies, policies, processes, and procedures that have been established by the governing body. Whereas governance is concerned with "doing the right thing," management is concerned with "doing things right."
11. Compliance with generally accepted principles of good governance. To what extent are the governance and management structures and processes well articulated and working well to bring about legitimate and effective governance and management? To what extent do governance and management practices comply with the following seven principles: • Legitimacy — the way in which governmental and managerial authority is exercised in relation to those with a legitimate interest in the program — including shareholders, other stakeholders, implementers, beneficiaries, and the community at large? • Accountability — the extent to which accountability is defined, accepted, and exercised along the chain of command and control within a program, starting with the annual general meeting of the members or parties at the top and going down to the executive board, the chief executive officer, task team leaders, implementers, and in some cases, to the beneficiaries of the program? • Responsibility — the extent to which the program accepts and exercises responsibility to stakeholders who are not directly involved in the governance of the program and who are not part of the direct chain of accountability in the implementation of the program?

Evaluation Criteria and Questions
• Fairness — the extent to which partners and participants, similarly situated, have equal opportunity to influence the program and to receive benefits from the program? • Transparency — the extent to which a program's decision making, reporting, and evaluation processes are open and freely available to the general public? • Efficiency — the extent to which the governance and management structures enhance efficiency or cost-effectiveness in the allocation and use of the program's resources? • Probity — the adherence by all persons in leadership positions to high standards of ethics and professional conduct over and above compliance with the rules and regulations governing the operation of the program?
12. Partnerships and participation To what extent has the program identified a complete list of stakeholders, or "stakeholder map", including the agreed-upon or perceived roles and responsibilities of the categories of stakeholders identified? To what extent is this a routine programmatic function, updated regularly, and transparently available? Has the program adopted primarily a shareholder model of governance (in which membership on the governing body is limited to financial and other contributors), or a stakeholder model (in which membership also includes non-contributors)? To what extent, if any, is the program's legitimacy being sacrificed in order to achieve greater efficiency, or vice-versa?
13. Programs located in host organizations To what extent is the location of the program in the Bank or other partner organization adversely affecting the governance, management, or other aspects of the program, such as compliance with the principles of transparency and fairness? For which functions is the program manager accountable to the host organization and the governing body of the program, respectively? Are conflicts of interest being managed appropriately? To what extent does the host organization play such a dominant role in the program, thereby reducing the incentives of other partners to participate effectively, or reducing the ability of the host organization to look at the weaknesses of the program objectively?
Resource mobilization and financial management: Resource mobilization — the processes by which resources are solicited by a program and provided by donors and partners. Financial management — the processes that govern the recording and use of funds, including allocation processes, crediting and debiting of accounts, controls that restrict use, accounting, and periodic financial reporting systems. In cases where funds accumulate over time, this would also include the management of the cash and investment portfolio.
14. Resource mobilization To what extent has the program succeeded in raising financial resources commensurate with its objectives? And from what sources — the Bank, bilateral donors, foundations, etc.? To what extent has the program succeeded in diversifying its funding beyond a small number of donors? To what extent are the sources of funding for the program (including donor restrictions on the use of resources) affecting, positively or negatively: • The strategic focus of the program? • The outputs and outcomes of the program? • The governance and management of the program? • The sustainability of the program?

Evaluation Criteria and Questions
15. Financial management Are there any issues that have emerged during the course of the review in relation to: • The quality of financial management and accounting? • The methods, criteria, and processes for allocating funds among different activities of the program? • Financial management during the early stages of the program?
Sustainability, risk, and strategy for devolution or exit: Sustainability — When applied to the activities of a program, the extent to which the benefits arising from these activities are likely to continue after the activities have been completed. When applied to a program itself, the extent to which the organization or program is likely to continue its operational activities over time. Devolution or exit strategy — a proactive strategy to change the design of a program, to devolve some of its implementation responsibilities, to reduce dependency on external funding, or to phase out the program on the grounds that it has achieved its objectives or that its current design is no longer the best way to sustain the results which the program has achieved.
16. Sustainability of the benefits of the program's activities What is the risk, at the time of evaluation, that the development outcomes (or expected outcomes) of the program will not be maintained (or realized)? This depends on (a) the likelihood that some changes may occur that are detrimental to maintaining or realizing the expected outcomes, and (b) the affect on the expected outcomes if some or all of these changes actually materialize?
17. Sustainability of the program This will depend on a number of factors, such as the continued legitimacy of the program, its financial stability, its continuity of effective management, and its ability to withstand changing market or other conditions. To what extent is there still a sufficient convergence or accommodation of interests among the major partners to sustain the program financially? To what extent has the program developed institutional capacity such as performance-based management, personnel policies, learning programs, and knowledge management that help to sustain a program? In what areas could the program improve in order to enhance its sustainability, such as better marketing of the program's achievements in order to sustain its reputation?
18. Prospects for continuation and strategies for devolution or exit To what extent should the program be sustained? Is the continuation of the program the best way of sustaining the results achieved? Should the design of the program be modified as a result of changed circumstances, either positive or negative? What other alternatives should be considered to sustain the program's results more cost-effectively, in the light of the previous evaluation findings with respect to relevance, efficacy, efficiency, and sustainability: • Reinventing the program with the same governance? • Phasing out the program? • Continuing country or local-level activities with or without devolution of implementation? • Seeking alternative financing arrangements, such as revenue-generation, or self-financing to reduce dependency on external sources? • "Spinning off" from the host organization?

Annex Table 3. Assessing the Bank's Performance as a Partner in the Program

Evaluation Questions
1. Comparative advantage at the global/regional level. To what extent is the Bank playing up to its comparative advantages at the global/regional level — its global mandate and reach and convening power? To what extent is the Bank's presence as a partner in the program catalyzing other resources and partners for the program?
2. Comparative advantage at the country level. To what extent is the Bank contributing multi-sector capacity, analytical expertise, and country-level knowledge to the program? To what extent has the Bank's country operations established linkages to the GRPP, where appropriate, to enhance the effectiveness of both?
3. Oversight. To what extent is the Bank exercising effective and independent oversight of its involvement in the program, as appropriate, whether the program is housed in the Bank or externally managed? To what extent is the Bank's oversight independent of the management of the program? To what extent does the Bank's representative on the governing body have a clear terms of reference?
4. Risks and risk management. To what extent have the risks associated with the program been identified and are being effectively managed? For example, IEG identified the following risks in its global review: • Bank bears a disproportionate share of responsibility for governing and managing in-house programs? • Confusion at the country level between global program activities, Bank activities, and Borrower activities? • Representation of NGOs and the commercial private sector on program governing bodies? • Unclear role and application of Bank's safeguards? • Trust-funded consultants and seconded staff representing the Bank on some program governing bodies?
5. Disengagement strategy. To what extent is the Bank engaged at the appropriate level in relation to the Bank's new strategic framework: • Watching brief? • Research and knowledge exchange? • Policy or advocacy network? • Operational platform? To what extent is the Bank facilitating an effective, flexible, and transparent disengagement strategy for the program, in relation to the Bank's objectives for its involvement in the program: • The program declares "mission accomplished" and closes? • The program continues and the Bank withdraws from all aspects of its participation? • The program continues and the Bank remains engaged, but the degree of the Bank's engagement in some or all aspects (such as financing) declines over time?

Annex Table 4. Common GRPP Activities

Advocacy and knowledge networking	
1. Facilitating communication among practitioners in the sector	This includes providing a central point of contact and communication among practitioners who are working the sector or area of development to facilitate the sharing of analytical results. It might also include the financing of case studies and comparative studies.
2. Generating and disseminating information and knowledge	This comprises two related activities. The first is gathering, analyzing and disseminating information, for example, on the evolving HIV/AIDS epidemic and responses to it, including epidemiological data collection and analysis, needs assessment, resource flows, and country readiness. The second is the systematic assembling and dissemination of knowledge (not merely information) with respect to best practices in a sector on a global/regional basis.
3. Improving donor coordination	This should be an active process, not just the side effect of other program activities. This may involve resolving difficult interagency issues in order to improve alignment and efficiency in delivering development assistance.
4. Advocacy	This comprises proactive interaction with policymakers and decision makers concerning approaches to development in a sector, commonly in the context of global, regional, or country-level forums. This is intended to create reform conditions in developing countries, as distinct from physical and institutional investments in public goods, and is more proactive than generating and disseminating information and knowledge.
5. Implementing conventions, rules, or formal and informal standards and norms	Rules are generally formal. Standards can be formal or informal, and binding or nonbinding, but implementing standards involves more than simply advocating an approach to development in a sector. In general, there should be some costs associated with noncompliance. Costs can come in many forms, including exposure to financial contagion, bad financial ratings by the IMF and other rating agencies, with consequent impacts on access to private finance; lack of access to OECD markets for failing to meet food safety standards, or even the consequences of failing to be seen as progressive in international circles.
Financing technical assistance	
6. Supporting national-level policy, institutional, and technical reforms	This is more directed to specific tasks than advocacy. This represents concrete involvement in specific and ongoing policy, institutional, and technical reform processes in a sector, from deciding on a reform strategy to implementation of new policies and regulations in a sector. It is more than just conducting studies unless the studies are strategic in nature and specific to the reform issue in question.
7. Capacity strengthening and training	This refers to strengthening the capacity of human resources through proactive training (in courses or on-the-job), as well as collaborative work with the active involvement of developing country partners.
8. Catalyzing public or private investments in the sector	This includes improving regulatory frameworks for private investment and implementing pilot investments projects.
Financing investments	
9. Financing country-level investments to deliver national public goods	This refers primarily to physical and institutional investments of the type found in Bank loans and credits (more than the financing of studies), the benefits of which accrue primarily at the national level.
10. Financing country-level investments to deliver global/regional public goods	This refers primarily to physical and institutional investments of the type found in Bank loans and credits (more than the financing of studies) to deliver public goods such as conserving biodiversity of global significance and reducing emissions of ozone-depleting substances and carbon dioxide, the benefits of which accrue globally.
11. Financing global/ regional investments to deliver global/regional public goods	This refers to financing research and development for new products and technologies. These are generally physical products or processes — the hardware as opposed to the software of development.

Annex B: Program Timeline

Year & Month	Pre-Partnership Events
1988	Stop TB Department created at WHO; Arata Kochi appointed Director
1991 May	World Health Assembly issues resolution WHA44.8, recognizing the growing importance of TB as a public health problem and the potential for cost-effective control. The resolution sets targets of curing 85% of sputum positive patients under treatment and detecting 70% of cases by year 2000
1994	With the estimated annual global TB incidence rate at 8 million and the annual TB death rate at 1–2 million, WHO announces a global emergency WHO issues the "Framework for Effective TB Control", a strategy based on a five-point policy package comprised of political commitment, passive case-finding with sputum microscopy, standardized short-course combination therapy, standardized monitoring and evaluation system, and uninterrupted drug supply
1995	WHO's tuberculosis control framework, officially branded DOTS (Directly Observed Treatment, Short-course), is formally adopted as the standardized strategy for TB management
1998 March	First Ad Hoc Committee on the TB Epidemic held in London. Participants call for increased political commitment to eliminate tuberculosis, a global charter to solidify agreement between international agencies, donors and governments of endemic countries on expanding DOTS coverage to meet the WHO targets for 2000, and establishment of a global drug facility for procurement and distribution
May	World Health Assembly issues resolution WHA51.13, urging Member States to take necessary steps to meet the 2000 targets and clearly establishing the need for an international partnership to expand tuberculosis control. WHO Director-General Gro Harlem Brundtland launches the Stop TB Initiative.
2000 February	A meeting of 120 representatives from academia, industry, NGOs, and donors in Cape Town, South Africa produces the "Declaration of Cape Town", outlining the need for the creation of the TB Alliance as an innovative product development partnership to accelerate the discovery and development of new anti-tuberculosis drugs
March	Ministers of Health, Planning and Finance from the 20 highest burden countries meet at the Ministerial Conference on TB and Sustainable Development and endorse the "Stop TB Partnership". Participants produce the Amsterdam Declaration to Stop TB, calling for accelerated action to improve drug supply, access to treatment, delivery systems, and treatment of patients with drug-resistant tuberculosis. Countries declare their intention to work in concert with WHO, the World Bank and others to create a global partnership agreement to Stop TB and a Global Fund for Tuberculosis, and to facilitate research into development of new tools (diagnostics, drugs, vaccines)
May	World Health Assembly issues resolution 53.1 supporting the establishment of the Stop TB Initiative, encouraging all Member States to endorse the Amsterdam Declaration, and extending the original targets for 2000 to 2005
October	Six Working Groups are created as structural and functional elements of the nascent Stop TB Partnership

December	The TB Alliance is officially launched at the International Conference on Health Research for Development in Bangkok, Thailand Dr. J.W. Lee appointed Director of Stop TB at WHO; Jacob Kumaresan appointed Executive Secretary of the Stop TB Initiative/Partnership
	Partnership Inception
2001 February	Representatives from high-burden countries, regions, donors, non-governmental organizations/technical agencies, Stop TB working groups, WHO, the World Bank, and the Stop TB Partnership Secretariat meet at an interim Coordinating Board meeting hosted by the Rockefeller Foundation in Bellagio, Italy The Global Drug Facility is established "to expand access to, and availability of, high-quality TB drugs to facilitate DOTS expansion"
March	First official Global Stop Tuberculosis Partners' Forum held in Washington, D.C. Partners endorse the formal structure of the Stop TB Partnership, issue the Endorsed Washington Commitment, and officially launch the Global Plan 2001–2005
October	First Stop TB Coordinating Board meeting held in Annapolis, Maryland
2002	WHO issues "An Expanded DOTS Framework for Effective Tuberculosis Control" to adapt the DOTS strategy to overcome roadblocks such as weak political will, the increasing impact of HIV on TB, and emergent drug resistance, as well as to facilitate integration into primary health care and health sector reform.
2003	JW Lee appointed new DG of WHO; Mario Raviglione appointed Director of Stop TB Department; Marcos Espinol appointed Executive Secretary of Stop TB Partnership.
2004 March	Second Stop TB Partners' Forum held in New Delhi, India. The New Delhi Pledge, "Keeping the Pledge to Stop TB", reaffirms ministerial commitments to meet the targets for 2005, and sets urgent priorities for expanding DOTS coverage and improving management of TB-HIV and MDR-TB.
2005 May	The World Health Assembly, concerned that increasing drug resistance and lack of commitment to sustained financing will inhibit achievement of the TB-relevant MDG, issues resolution WHA58.13 encouraging the development of a global plan for the period 2006–2015
2006 March	The Stop TB Strategy (included in the Global Plan 2006–2015 and officially released in January) is launched on World TB Day
2007 May	World Health Assembly issues resolution WHA60.19, welcoming the Global Plan 2006–2015 and urging Member States to implement long-term plans for TB prevention
2008 April	McKinsey & Company release an independent external evaluation of the Stop TB Partnership, commissioned by the Stop TB Coordinating Board.

Source: Author and Stop TB Partnership Web site (http://www.stoptb.org) and documents.

Annex C: Core Partnership Documents and WHA Resolutions

Core Partnership Documents	WHA Resolutions
	WHA44.8, May 1991 **Requests to the Director-General:** • To intensify collaboration with Member States in strengthening national control programmes in order to improve case-finding and treatment and attain a global target of cure of 85% sputum positive patients under treatment and detection of 70% of cases by the year 2000
	WHA51.15, May 1998 **Urges all Member States:** • To take the necessary steps, especially in those 17 countries with the highest burden of disease that are not expected to meet the targets by the year 2000: • To review the constraints faced in meeting the targets, if necessary with support from WHO, development agencies or nongovernmental organizations • To meet the targets through implementation and expansion of the DOTS strategy **Calls on the international community,** organizations and bodies of the United Nations system, donors, nongovernmental organizations and foundations: • To mobilize and sustain external financial and operational support
Amsterdam Declaration from the Ministerial Conference on TB and Sustainable Development, March 2000 Ministers of Health, Planning and Finance from the 20 countries home to 80% of the world's TB cases declare their intention, and call on colleagues from other nations, to join WHO, the World Bank and others in the Stop TB Initiative to actively participate in building new momentum against tuberculosis for better health for all in the new millennium. **Countries commit to:** • expand DOTS coverage to provide for at least 70% infectious case detection by 2005. • implement monitoring and evaluation systems for national TB programs in line with WHO standards • improve procurement and distribution systems for TB drugs to ensure quality, access, transparency, and timely supply • promote the development of national and international partnerships to stop TB with all stakeholders in society • actively participate in the development and implementation of a global partnership agreement to Stop Tuberculosis designed to foster ownership	**WHA53.1, May 2000** **Being mindful** of the fact that most countries with the greatest burden of disease will not meet global targets for tuberculosis control for 2000 **Welcoming** the establishment, in response to resolution WHA51.13, of a special Stop Tuberculosis Initiative to accelerate action against the disease and to coordinate activities across WHO **Encourages all Member States:** • To endorse the Amsterdam Declaration to Stop Tuberculosis, as an outcome of the Ministerial Conference on Tuberculosis and Sustainable Development (Amsterdam, March 2000) • To accelerate tuberculosis control by implementing and expanding DOTS **Recommends that Member States should:** • Participate with WHO in the global partnership to stop tuberculosis, and establish and sustain country-level partnerships **Calls on** the international community, organizations and bodies of the United Nations system, donors, nongovernmental organizations and foundations: • To support and to participate in the global partnership to stop tuberculosis by which all

Core Partnership Documents	WHA Resolutions
and accountability **Call upon partners to commit resources to:** • develop and strengthen national development plans that incorporate health development and tuberculosis control as essential components • build new international approaches toward ensuring universal access to, and efficient national systems of, procurement and distribution of anti-TB drugs • accelerate basic and operational research for the development and delivery of new tools, including diagnostics, drugs and vaccines	parties coordinate activities and are united by common goals, technical strategies, and agreed-upon principles of action • To increase organizational and financial commitment towards combating tuberculosis within the context of overall health sector development **Requests the Director-General** to provide support to Member States, particularly those with the highest tuberculosis burden, by: • Exploring partnerships and options for enhancing access to safe, high-quality curative drugs • Sustaining an active and participatory partnership with external organizations throughout the development and implementation of the Stop Tuberculosis Initiative and its activities
Washington Commitment to Stop TB, from the first Stop TB Partners' Forum, October 2001 **Convened by the Director-General of WHO and the President of the World Bank** Partners, including representatives from national governments of the 18 highest TB burden countries **commit to sharing resources by:** • providing technical assistance to support global, regional and national stop TB programs and activities • mobilizing increased financial resources for countries and partners in support of the Global Plan Partners **commit to working in partnership by:** • endorsing the Framework of the Global Partnership to Stop TB • collaborating through Stop TB Working Groups and other operational structures established by the partnership to achieve the objectives of the Global Plan to Stop TB • supporting the further development of the Global TB Drug Facility and other initiatives of the Global Partnership to Stop TB	
Global Plan to Stop TB 2001–2005 **Objectives:** • **To expand** our current strategy – DOTS – so that all people with TB have access to effective diagnosis and treatment • **To adapt** this strategy to meet the emerging challenges of HIV and TB drug resistance • **To improve** existing tools by developing new diagnostics, new drugs and a new vaccine • **To strengthen** the Global Partnership to Stop TB so that proven TB-control strategies are effectively applied	

Core Partnership Documents	WHA Resolutions
Keeping the Pledge to Stop TB, from the Second Stop TB Partners' Forum, March 2004 With only 20 months left to meet the global targets for TB control set by WHA Resolution 44.8 in 2000, the **delegates of the Second Stop TB Partners' Forum affirm commitment to:** • intensify efforts towards achieving the 2005 targets • accelerating action to expand DOTS coverage • expanding outreach to include key new partners, such as private practitioners, nongovernmental organizations, • the private sector, those at risk of or already living with • HIV/AIDS, and ultimately all of civil society • mobilizing more resources, both in cash and in kind, to facilitate the push towards the 2005 targets and beyond those towards the Millennium Development Goals of reducing TB prevalence and mortality by half by 2015 **The Partners' Forum states that:** • The Global Partnership to Stop TB is working effectively • Despite significant strides made since 2001, progress could be reversed without rapid action • There is an urgent need to accelerate DOTS expansion, prevention, and management of HIV/AIDS and MDR-TB through partnership-building and to invest in new tools – diagnostics, TB drugs and vaccines National governments and other Stop TB partners acknowledge historically unprecedented resources, and pledge to build on progress to date and to fulfill commitments made in Amsterdam and Washington.	**WHA58.13, May 2005** **Noting with concern** the increasing number of cases of multi-drug resistant tuberculosis and worsening morbidity and mortality among HIV-positive tuberculosis patients, especially in the African Region **Stressing** the importance of engagement of the full range of health providers in delivering the international standard of tuberculosis care in line with the strategy of DOTS Concerned that lack of commitment to sustained financing for tuberculosis control will impede the sound long-term planning necessary to achieve the internationally agreed development goal relevant to tuberculosis contained in the UN Millennium Declaration **Encouraging** the development of a global plan for the period 2006–2015 **Encourages all Member States:** • To estimate the total resources required for prevention and control of tuberculosis, including HIV-related TB and MDR-TB • To fulfill the commitments made in endorsing resolution WHA53.1 and hence the Amsterdam Declaration to Stop TB • To integrate the prevention and control of tuberculosis in the mainstream of their health development plans **Requests the Director-General:** • To strengthen cooperation with Member States with a view to improving collaboration between tuberculosis programs and HIV programs • To implement and strengthen strategies for the effective control of, and management of persons with, drug-resistant tuberculosis • To take the lead in cooperation with national health authorities in working with partners to devise, strengthen and support mechanisms to facilitate sustainable financing of tuberculosis control • To enhance WHO's support to the Stop TB Partnership • To promote research and development for new control tools as part of the global plan to stop tuberculosis
Global Plan 2006–2015 A comprehensive assessment of the action and resources needed to implement the Stop TB strategy and make an impact on the global TB burden **Objectives:** • Promote wider and wiser use of existing strategies to interrupt TB transmission by: o Increasing access to accurate diagnosis and effective treatments by accelerating DOTS implementation to achieve the global targets for TB control; and o Increasing the availability, affordability and	**WHA60.19, May 2007** **Noting** the progress made since 1991 towards achieving the international targets for 2005, and more recently following the establishment, in response to resolution WHA51.13, of the Stop TB Partnership **Aware** of the need to build on this progress and overcome constraints in order to reach the international targets for TB control for 2015 set by the Stop TB Partnership **Noting** the development of the Stop TB strategy as a comprehensive approach to tuberculosis prevention and control that incorporates the internationally agreed

Core Partnership Documents	WHA Resolutions
quality of anti-TB drugs • Derive strategies to address the challenges posed by emerging threats by adapting DOTS to prevent and manage multidrug-resistant TB, and to reduce the impact of HIV-related TB • Accelerate the elimination of TB by: o Promoting research and development for new TB diagnostic tests, drugs and vaccines; and o Promoting adoption of new and improved tools by ensuring appropriate use, access and affordability **Targets:** • Reducing incidence in line with MDG6 • Halving TB prevalence and deaths by 2015 compared with 1990 levels **Strategic Plan** for accomplishing Partnership Goals by 2015 and eliminating TB by 2050 through: • Implementation Working Group Plans • DOTS Expansion • TB/HIV • MDR-TB • New Tools Working Group Plans • Diagnostics • Drugs • Vaccines	TB control strategy (DOTS) and represents a significant expansion in the scale and scope of TB control **Welcoming** the Partnership's Global Plan to Stop TB 2006–2015 **Concerned** that delays in implementing the Global Plan will result in increasing numbers of tuberculosis cases and deaths, including those due to MDR and XDR-TB and to the impact in HIV **Recognizing** the importance of the situation and the trends of MDR and XDR-TB as barriers to achievements of the Global Plan's objectives for 2015, and the need for an increased number of Member States participating in the network of the Global Project on Anti-Tuberculosis Drug Resistance Surveillance and for the required additional resources to accomplish its task **Urges all Member States:** To develop and implement long-term plans for TB prevention and control in line with the Global Plan 2006–2015, with the aim of: • accelerating improvement of health-information systems • ensuring high-quality DOTS implementation • controlling the emergency and transmission of MDR-TB • if affected, immediately addressing XRD-TB and HIV-related TB as part of the overall Stop TB strategy, as the highest health priorities • enhancing laboratory capacity • increasing access to quality-assured second-line medicines at affordable prices through the Stop TB Green Light Committee • accelerating collaborative interventions against HIV and TB • fully involving the private sector in national TB control programs

Source: Author and Stop TB Partnership Web site (http://www.stoptb.org) and documents.

Annex D. The Global Drug Facility

Mandate	• Address the central problem of providing an uninterrupted supply of anti-TB drugs • Ensure uninterrupted access to high-quality anti-TB drugs for national TB control programs to implement the DOTS treatment strategy • Catalyze rapid DOTS expansion to achieve WHO global targets for TB control • Generate worldwide political and public commitment for public funding of anti-TB drug supplies
Services	**Grant-making** for first-line drugs to qualifying countries (based on Gross National Income) **Direct Procurement** to aid governments, donors and NGOs in purchasing drugs in countries with sufficient finances that lack procurement capacity (includes quality assurance system) **GDF Technical Support Service** mobilizes Stop TB partners to provide technical assistance (TA) for in-country management and monitoring of anti-TB drugs and supports global efforts to improve drug quality (primarily through WHO prequalification)
Governance Model	• Established by Stop TB Coordinating Board as an "embedded legal entity housed in WHO" • WHO – provides legal identity; facilitates access to country and regional offices; coordinates with DOTS Expansion Working Group; houses secretariat that provides administrative support, manages procurement and mobilizes partners for TA • Stop TB Partnership – provides funding and TA through partners • Coordinating Board – reviews annual work plans and Technical Review Committee (TRC) recommendations in relation to grants
Core Donors	Canadian International Development Agency (CIDA) Government of the Netherlands United States Agency for International Development (USAID) World Bank
Procurement Agents	GTZ (current contract 2006–2008) International Dispensary Association (2nd line)
Quality Control Agent	Intertek Technical Inspections
Innovative "Bundled" Procurement	• Ensures any grants given are in addition to existing resources • Competitively outsources all services to partners demonstrating technical and/or financial advantage • Simplifies drug management through product and packaging standardization • Combines international public sector policy and private sector technologies and operating procedures for improved efficiency
Primary Achievements	• Patient treatment – Catalyzing DOTS expansion • Access to high-quality drugs • Reduced TB drug prices, competitiveness/cost-effectiveness • Equity of Access (annual per capita GNI restriction for grants and drugs provided free of charge; countries using DP Service benefit from same prices and range of services) • Standardization of products • Flexible supply system meets differing program needs

Sources: Kumaresan, J., et al., "The Global TB Drug Facility: Innovative Global Procurement," *International Journal of Tuberculosis and Lung Disease* 8(1): p. 130–38, 2004.; Matiru, R. and T. Ryan. "The Global Drug Facility: A Unique, Holistic and Pioneering Approach to Drug Procurement and Management*," Bulletin of the World Health Organization* 85(5): p. 348–53; 2007. McKinsey & Company, *Evaluation of Global TB Drug Facility*, 2003.; Vrakking, H. and A. de Lucia, *Global Drug Facility: An Innovative Approach to Supplying anti-TB Drugs*, 2008.

Annex E. The Green Light Committee (GLC) Initiative of the Working Group on MDR-TB

Mandate	• Increase access to high-quality, low-cost 2nd line TB medications for the treatment of MDR-TB • Prevent development of resistance to TB drugs through standardized treatment of patients with MDR-TB in accordance with WHO guidelines • Provide technical assistance to countries to facilitate rapid scale-up of MDR-TB management • Provide technical policy and procedural support for drug-resistant TB to WHO and its members
Services	• Providing expertise in development and management of MDR-TB programs. • Advising and negotiating for procurement of quality-controlled, affordable second line TB medications (actual procurement undertaken by GDF) • Providing external review of GLC-approved programs to improve management of MDR-TB patients
Governance Model	• "Technical advisory body" composed of 9 institutions involved with Working Group on MDR-TB; reviews applications and supports technical assistance for MDR-TB programs, partakes in M&E of programs, and assists WHO in policy formulation • WHO technical assistance, administers Secretariat • GLC Secretariat overall coordination of activities, monitoring and evaluation (M&E) • GDF Secretariat drug-procurement arm; negotiates second-line drug price reductions
Application Process	• TB programs in countries with need for improved access to second line TB medications and assistance in managing TB resistance can submit application to Secretariat • Programs must meet certain laboratory and health facility capability standards and be able to guarantee implementation of Directly Observed Therapy (DOT) guidelines • GLC, meeting every two months to review applications, will assess applicant program and, with involvement of Secretariat, identify areas of concern in application • Technical teams from GLC visit program • Once program is approved, Secretariat will communicate with applicant program and GDF to begin procurement
Quality Control	WHO prequalification
Core Donors	Global Fund, UNITAID, WHO, OGAC, USAID Bill and Melinda Gates Foundation, Eli Lilly
Primary Achievements	Since inception in 2000, GLC Initiative has approved 137 applications from TB programs in 61 countries Ninety-four projects have been approved, amounting to 52,448 approved patients globally. Information collected from experience of programs has contributed to global base of knowledge and international drug-resistant TB management policy

Source: GLC Initiative: Frequently Asked Questions. http://www.who.int/tb/challenges/mdr/greenlightcommittee/en/index.html.

Annex F: Overview of Working Groups

Stop TB Partnership Working Groups	Established
DOTS Expansion Working Group Subgroups: • Public-Private Mix • ACSM at Country Level • Childhood TB • TB and Poverty	2001; an inter-institutional arrangement between WHO, major financial and technical partners, national TB control programmes, the Global Drug Facility (GDF), and community representatives to expand access to TB diagnosis and treatment in line with the MDG and Stop TB Partnership targets
Working Group on MDR-TB	1999 as the Working Group on DOTS-Plus for MDR-TB and renamed in May 2006; representatives of countries, bilateral and multilateral agencies, international organizations, non-governmental organizations, community representatives, pharmaceutical industries and universities working to advance MDR-TB surveillance and control
TB/HIV Working Group	2001; to coordinate, monitor, advise, collect and share information around the global response to the HIV associated TB epidemic
Working Group on New TB Diagnostics	2001; to advocate and implement research and/or operational activities in pursuit of the development and implementation of TB diagnostic tool; collaborate with Special Programme for Research and Training in Tropical Diseases (TDR),Foundation for Innovative New Diagnostics (FIND) and industry.
Working Group on New TB Drugs	2001; to ensure that scientists, academics, pharmaceutical companies, donors, multilaterals, and patients themselves are working together to speed the development of new drugs for TB; members are individuals rather than organizations and include those working in basic research and TB drug R&D as well as regulators, funders, implementers, advocates, policy-makers and affected community representatives
Working Group on New TB Vaccines	2001; to bring together international groups to accelerate identification and introduction of the most effective vaccination strategy
Advocacy, Communication and Social Mobilization Working Group	Created 2001, Disbanded January 2009; Country-Level Sub-Group to support NTPs replaced with ACSM Sub-group of the DOTS Expansion WG; Global Advocacy Sub-Group replaced by small, expert Advocacy Advisory Committee providing direct advice and support to the Board and Secretariat

Source: Stop TB Partnership Web site (http://www.stoptb.org).

Annex G. DOTS Expansion Working Group

Established 2001

Inter-institutional arrangement between WHO, major financial and technical partners, national TB control programs, the GDF, and community representatives

Structure

- **Membership**
  - High-burden country representatives and Stop TB partner institutions (financial and technical agencies)
  - Open to any institution/agency supporting the goals of the Working Group
- **Core Team**
  - Established at the request of the secretariat to facilitate and accelerate decision making and set the strategic direction of the DEWG
  - Membership
    - Permanent members: The Union, KNCV Tuberculosis Foundation, GDF, and WHO
    - Non-permanent members: country representatives, representatives of financial partners, community representatives, representatives of other major technical agencies working in TB control
    - Chairs and Secretaries of the sub-groups
- **Chair**
  - Serves two-year renewable term
  - Defines key work and direction of DEWG, coordinates activities with sub-group chairs, convenes DEWG on an annual basis and chairs the meeting, convenes and chairs teleconferences and meetings of DEWG core team
- **Secretariat**
  - Hosted by WHO, operating under the WHO system within the TB Strategy and Health Systems unit of the Stop TB Department
  - Organizes DEWG and core group meetings, prepares agenda and relevant background working documents for meetings, prepares and distributes meeting reports, monitors implementation of recommendations, manages resources provided for functioning of the Working Group

Meetings held at least once a year, convened by the Chair and facilitated by the Secretariat housed at WHO

Four Sub-Groups:

- Public-Private Mix
- Advocacy, Coordination and Social Mobilization at Country Level
- Childhood TB
- TB and Poverty

Plan of Action 2008–2009

Objectives:

- To achieve and sustain performance beyond the “70/85” targets
- To further advance towards universal access to quality TB care for all people with TB, adults and children especially the poor and vulnerable, in line with the Stop TB strategy and the second Global Plan to Stop TB

Five Main Priorities

- Expanding service coverage, strengthening quality of DOTS implementation and increasing access to services for children;
- Laboratory strengthening to expand quality assured microscopy, culture and Drug Susceptibility Testing (DST) (currently included in the GLI proposal);
- Human resources development plan including mapping of existing resources from different health care providers with a focus on services to the poor;
- Linking existing health care providers to NTPs, including promotion of international standards for TB care (ISTC)
- Monitoring and evaluation impact measurement

Source: DOTS Expansion Web page, accessed from the Stop TB Partnership Web site, http://www.stoptb.org.

Annex H. 2008 Evaluation: Recommendations and Program Response

	Recommendation	Program Response and Actions
1	The Partnership should make progress against the Global Plan more visible, analyze it, and use it to influence Partner activities	• The draft of the Global Plan Progress Report to be discussed at the next Board meeting (28-29 October 2008, Bagamoyo, Tanzania). • The Global Plan Progress Report to be released at the Partners' Forum, 23-25 March 2009, Rio de Janeiro, Brazil.
2	The Partnership should focus on four roles where it adds value over and above Partners and other organizations, and articulate a Partnership-level strategy for delivery impact through these roles	• The Partnership to continue with its efforts to get remaining countries to align their national plans with the Global Plan. • Develop and publish a brochure briefly covering the vision of the Secretariat and Working Groups and how these contribute to the Global Plan. • A short strategic component to be prepared as a preamble to the next biennium Work Plan.
3	The Partnership should expand, strengthen, and systematize its advocacy efforts	An advocacy strategy will be compiled. The strengthened advocacy and communication team in the Secretariat will be entrusted with: • Development of a comprehensive biennium strategy. • Structured reporting in the Annual Report and dedicated presentations at the Coordinating Board meetings. • A systematic review of the portfolio of ACSM products and activities. • Better coordination of all multi-tier and multi-channel advocacy efforts. • Targeting decision makers in countries to secure release of more resources for TB control.
4	The Partnership should become a global resource for coordinating technical assistance to countries and for sharing best practices	• Strengthen database of technical expertise and ensure it is widely available. • Streamline work in collaboration with GLC and GDF.
5	The Partnership should continue to operate GDF in its current form, and use it to accelerate sustainable transformation of TB control in priority countries over the next 3-4 years).	• Deeper engagement of GDF with Partners to persuade countries to honor their commitment as set out in GDF Grant Agreements. • Further elaboration of GDF's long term vision in the Global Plan. • Maintain focus on the procurement of anti-TB drugs with a view to a gradual scaling down of grants for first line drugs (adults). This is provided market dynamics for first-line drugs continue to be positively influenced through either a proportional increase in direct procurement or another supply intervention. Emergency grants will continue to be important via GDF. • Conduct landscape analysis and discussion on improvements to TA intervention through close cooperation with TBTEAM. • Strengthen GDF's capacity for procuring second line drugs on a larger scale.

	Recommendation	Program Response and Actions
		• Targets to be set by GDF over the next three to five years. • Maintain close relationship with UNITAID.
6	The Partnership should maintain GLC in its current form for as long as it believes that the risks of misuse of second-line drugs require it	• Completion of hiring additional staff in the GLC Secretariat (3 to be hired). • Continuation of provision of technical assistance (TA) to countries embarking on programmatic management of the DR-TB (including, laboratory, drug management and infection control TA).
7	The Partnership should continue to use Working Groups as a major vehicle contributing to TB control and research, systematize the processes for their establishment and performance review, and provide them support from the Secretariat	• ExComm to review submitted Working Group applications ahead of the next Board meeting. • Further discussion on how to synchronize the updates of the Global Plan with the review of the Working Groups to take place after 18th August 2008.
8	The Partnership should strengthen performance management processes for Partnership bodies, and use performance transparency to encourage Partners to deliver on commitments	• The Secretariat will continue to report through WHO performance reporting mechanism. • Working Groups would report through their annual submission to the Partnership Annual Report. Metrics could be considered for some other bodies, though their development and tracking would need more staff at the Secretariat. • The Secretariat will be empowered to develop some metrics and track them subject to resources being available. • Development of appropriate metrics and tracking them resources permitting.
9	The Partnership should adjust the structure and function of the Coordinating Board to enhance constituency representation, review global and Partnership progress in TB control and research, and increase focus on debating high-level strategic issues.	• A gradual shift towards a constituency board will be made. • As a first move towards a constituency board, two or three additional constituency members per Board seat can attend the next Board meeting (28-29 October, Bagamoyo, Tanzania). • Various constituency meetings will be facilitated by the Secretariat at the Partners' Forum to strengthen constituency representation at the Coordinating Board. • A review of constituency representation at the Board would be conducted by the Coordinating Board following the deliberations at the Partners Forum.
10	The Partnership should align its organizational structure with the activities recommended above, and the Secretariat should conduct a detailed evaluation of the resources required to deliver the recommendations.	• Secretariat to advise on the best composition of the high level Board delegation for meeting WHO and develop an agenda for the meeting of the high level delegation from the Coordinating Board to WHO. • A further refinement of the preliminary estimated resource position, given actions already underway and forecasted resources, will be done by the Secretariat.

Source: Minutes of the Stop TB Coordinating Board, Executive Committee, July 17, 2008.

Annex I. Country Profiles

China

India

Russian Federation

South Africa

COUNTRY PROFILE

China

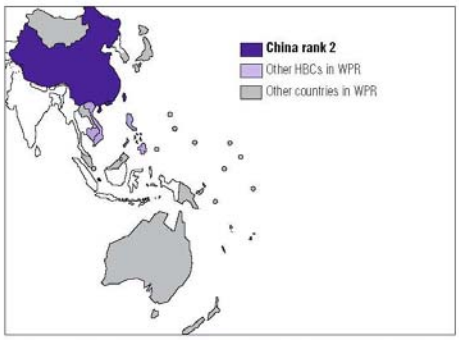
Having reached the global targets for case detection and treatment success for the second consecutive year, the Chinese NTP is now working to improve access to high-quality TB care for all people with TB, including those with TB/HIV, those with MDR-TB and unofficial internal migrants (the "floating populations"). Activities funded by the Global Fund round 5 grant will begin to address these challenges in selected counties. While the NTP has a comprehensive human resource development plan based on a needs assessment, information about human resources at sub-national levels is not available centrally. Nonetheless, the NTP identifies a shortage of trained staff as one of the challenges to implementing the Stop TB Strategy. The relationship between TB dispensaries run by the NTP and general hospitals continues to be problematic, and pilot projects are under way to improve collaboration.

SURVEILLANCE AND EPIDEMIOLOGY, 2006

Population (thousands)[a]	1 320 864
Estimates of epidemiological burden[1]	
Incidence (all cases/100 000 pop/yr)	99
Trend in incidence rate (%/yr, 2005–2006)[2]	**-1.0**
Incidence (ss+/100 000 pop/yr)	45
Prevalence (all cases/100 000 pop)[2]	**201**
Mortality (deaths/100 000 pop/yr)[2]	**15**
Of new TB cases, % HIV+[b]	*0.3*
Of new TB cases, % MDR-TB[c]	*5.0*
Of previously treated TB cases, % MDR-TB[c]	*26*
Surveillance and DOTS implementation	
Notification rate (new and relapse/100 000 pop/yr)	71
Notification rate (new ss+/100 000 pop/yr)	35
DOTS case detection rate (new ss+, %)	**79**
DOTS treatment success (new ss+ cases, 2005 cohort, %)	**94**
Of new pulmonary cases notified under DOTS, % ss+	55
Of new cases notified under DOTS, % extrapulmonary	4.3
Of new ss+ cases notified under DOTS, % in women	30
Of sub-national reports expected, % received at next reporting level[d]	100
Laboratory services[3]	
Number of laboratories performing smear microscopy	3 010
Number of laboratories performing culture	360
Number of laboratories performing DST	90
Of laboratories performing smear microscopy, % covered by EQA	92
Management of MDR-TB	
Of new cases notified, % receiving DST at start of treatment	0.0
Of new cases receiving DST at start of treatment, % MDR-TB	–
Of re-treatment cases notified, % receiving DST	0.0
Of re-treatment cases receiving DST, % MDR-TB	20
Collaborative TB/HIV activities	
National policy of counselling and testing TB patients for HIV?	Yes (for specific groups)
National surveillance system for HIV-infection in TB patients?	No
Of TB patients (new and re-treatment) notified, % tested for HIV	0.1
Of TB patients tested for HIV, % HIV+	1.3
Of HIV+ TB patients detected, % receiving CPT	144
Of HIV+ TB patients detected, % receiving ART	333

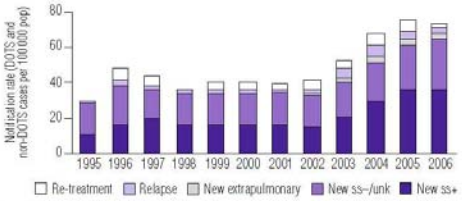
WHO Western Pacific Region (WPR)

Rank based on estimated number of incident cases (all forms) in 2006



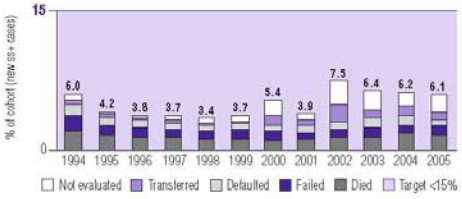
Case notifications

With the second year of full DOTS coverage, the overall notification rate is fairly steady, although the ss– notification rate has increased and re-treatment notification rate decreased



Unfavourable treatment outcomes, DOTS

Reported treatment success rate remains very high



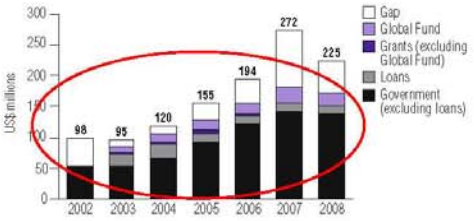
DOTS expansion and enhancement	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
DOTS coverage (%)	49	60	64	64	64	68	68	78	91	96	100	100
DOTS notification rate (new and relapse/100 000 pop)	13	21	24	27	27	27	28	30	43	58	68	71
DOTS notification rate (new ss+/100 000 pop)	7.5	14	16	16	14	15	14	14	20	29	36	35
DOTS case detection rate (all new cases, %)	11	18	21	24	24	24	25	27	37	52	64	68
DOTS case detection rate (new ss+, %)	15	29	32	32	30	31	31	30	43	64	80	79
Case detection rate within DOTS areas (new ss+, %)[e]	31	47	50	50	46	45	45	39	47	66	80	79
DOTS treatment success (new ss+, %)	96	96	96	97	96	95	96	93	94	94	94	–
DOTS re-treatment success (ss+, %)	92	94	–	95	95	89	93	88	89	89	90	–

CHINA

FINANCING THE STOP TB STRATEGY

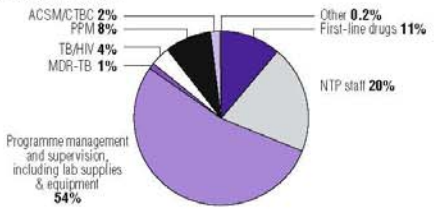
NTP budget by source of funding

Continued increase in NTP budget and funding up to 2007, but reduction in both in 2008; most financing is from domestic sources



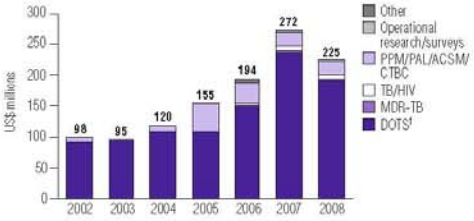
NTP budget by line item, 2008

85% of budget is for component 1 of the Stop TB Strategy (DOTS expansion and enhancement); budget for MDR-TB is small – plans for treatment cover less than 1% of estimated MDR-TB cases



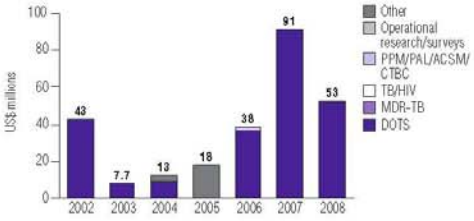
NTP budget by line item

Large increase in budget in 2007 to allow for purchase of essential equipment and vehicles; budget in all years mostly for DOTS; budget for MDR-TB includes US$ 1153 per patient for second-line drugs



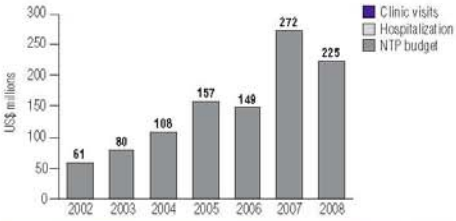
NTP funding gap by line item

Funding gaps are for DOTS component of Stop TB Strategy, and within this mainly for routine programme management and supervision activities, and laboratory supplies and equipment



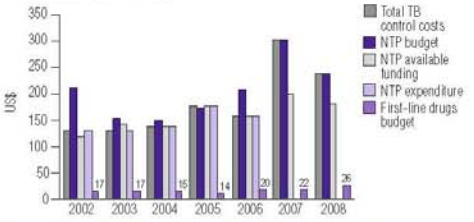
Total TB control costs by line item[4]

All costs for TB control are included in the NTP budget



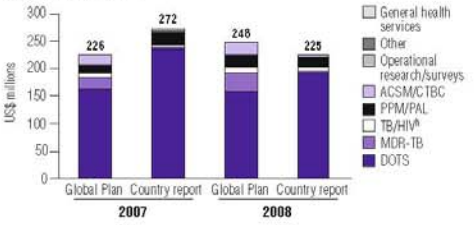
Per patient costs, budgets and expenditures[5,6]

Increasing budget per patient with peak in 2007 due to purchase of capital items such as vehicles and equipment in that year



Comparison of country report and Global Plan: total TB control costs, 2007–2008

Country report is ahead of Global Plan expectations for DOTS, but far behind for MDR-TB and ACSM; Global Plan targets for patients to be treated for MDR-TB are from the Global MDR/XDR Response Plan



NTP budget and funding gap by Stop TB Strategy component

	2007		2008	
(US$ millions)	BUDGET	GAP	BUDGET	GAP
DOTS expansion and enhancement	238	91	191	52
TB/HIV, MDR-TB and other challenges	7.4	0	11	0.5
Health system strengthening	0	0	0	0
Engage all care providers	19	0	19	0
People with TB, and communities	5.8	0	4.2	0
Research	1.0	0	0	0
Other	0.5	0	0.5	0

Financial indicators for TB

Government contribution to NTP budget (including loans)	56%	67%
Government contribution to total cost TB control (including loans)	56%	67%
NTP budget funded	66%	77%
Per capita health financial indicators (US$)		
NTP budget per capita	0.2	0.2
Total costs for TB control per capita	0.2	0.2
Funding gap per capita	0.07	0.04
Government health expenditure per capita (2004)	27	
Total health expenditure per capita (2004)	70	

SOURCES, METHODS AND ABBREVIATIONS

a–h Please see footnotes page 169.

1. Incidence, prevalence and mortality estimates include patients infected with HIV. Incidence rate of ss+ cases estimated on basis of annual risk of TB infection (ARTI) measured in 2000, and assumed to be declining at same rate as ARTI (1% per year).
2. MDG and STB Partnership indicators shown in bold. Targets are 70% case detection of smear-positive cases under DOTS, 85% treatment success, to ensure that the incidence rate is falling by 2015, and to reduce incidence rates and halve 1990 prevalence and mortality rates by 2015. Estimates for 1990 are prevalence 322/100 000 pop and mortality 24/100 000 pop/yr.
3. For routine diagnosis, there should be at least one laboratory providing smear microscopy per 100 000 population. To provide culture for diagnosis of paediatric, extrapulmonary and ss-/HIV+ TB, as well as DST for re-treatment and failure cases, there should be at least one culture facility and one DST facility in each of the 31 provinces.
4. Total TB control costs for 2002–2006 are based on expenditure, whereas those for 2007–2008 are based on budgets.
5. Estimates of expenditure are based on received funding.
6. NTP available funding for 2004–2006 is based on the amount of funding actually received, using retrospective data; available funding for 2002–2003 and 2007–2008 is based on prospectively reported budget data, and estimated as the total budget minus any reported funding gap.

– indicates not available; pop, population; ss+, sputum smear-positive; ss–, sputum smear-negative pulmonary; unk, pulmonary – sputum smear not done or result unknown; yr, year.

COUNTRY PROFILE

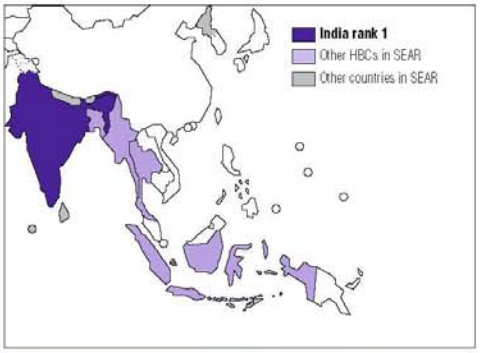
India

In reaching 100% DOTS coverage, the Revised National Tuberculosis Control Programme (RNTCP, hereafter NTP) of India has begun to operate in parts of the country that are particularly challenging. It remains to be seen if the Stop TB Strategy can be implemented as successfully in these districts as it has been in the rest of India. The introduction of MDR-TB treatment as part of routine programme activities will succeed only if the planned sub-national reference laboratories function properly, and if a reliable supply of high-quality second-line drugs is available. Plans to expand collaborative TB/HIV activities nationally will need to reflect the local variations in HIV epidemiology. Assessing the impact of TB control in India will require careful analysis of the extensive and detailed data that are routinely collected by the NTP, in addition to recent and planned surveys of the prevalence of infection and of disease.

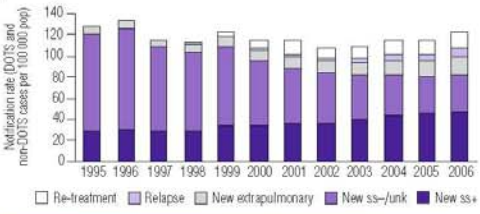
SURVEILLANCE AND EPIDEMIOLOGY, 2006

Population (thousands)[a]	1 151 751
Estimates of epidemiological burden[1]	
Incidence (all cases/100 000 pop/yr)	168
Trend in incidence rate (%/yr, 2005–2006)[2]	**0.0**
Incidence (ss+/100 000 pop/yr)	75
Prevalence (all cases/100 000 pop)[2]	**299**
Mortality (deaths/100 000 pop/yr)[2]	**28**
Of new TB cases, % HIV+[b]	*1.2*
Of new TB cases, % MDR-TB[c]	*2.8*
Of previously treated TB cases, % MDR-TB[c]	*17*
Surveillance and DOTS implementation	
Notification rate (new and relapse/100 000 pop/yr)	107
Notification rate (new ss+/100 000 pop/yr)[3]	48
DOTS case detection rate (new ss+, %)[3]	**64**
DOTS treatment success (new ss+ cases, 2005 cohort, %)	**86**
Of new pulmonary cases notified under DOTS, % ss+	58
Of new cases notified under DOTS, % extrapulmonary	16
Of new ss+ cases notified under DOTS, % in women	31
Of sub-national reports expected, % received at next reporting level[4]	100
Laboratory services[4]	
Number of laboratories performing smear microscopy	11 968
Number of laboratories performing culture	8
Number of laboratories performing DST	8
Of laboratories performing smear microscopy, % covered by EQA	79
Management of MDR-TB	
Of new cases notified, % receiving DST at start of treatment	0.0
Of new cases receiving DST at start of treatment, % MDR-TB	–
Of re-treatment cases notified, % receiving DST	0.0
Of re-treatment cases receiving DST, % MDR-TB	81
Collaborative TB/HIV activities	
National policy of counselling and testing TB patients for HIV?	Yes (for specific groups)
National surveillance system for HIV-infection in TB patients?	No
Of TB patients (new and re-treatment) notified, % tested for HIV	4
Of TB patients tested for HIV, % HIV+	15
Of HIV+ TB patients detected, % receiving CPT	–
Of HIV+ TB patients detected, % receiving ART	–

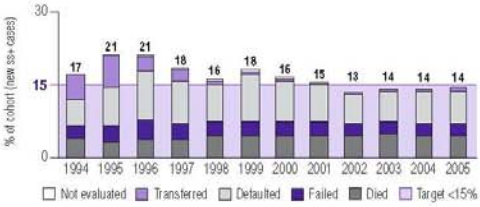
WHO South-East Asia Region (SEAR)
Rank based on estimated number of incident cases (all forms) in 2006



Case notifications
Notification rates of most case types increasing slightly, falling only for ss– pulmonary cases



Unfavourable treatment outcomes, DOTS
Treatment success rate target reached for 2001 cohort, but relatively unchanged since



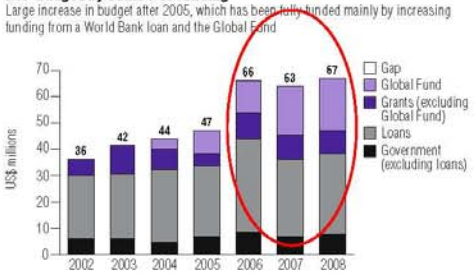
DOTS expansion and enhancement	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
DOTS coverage (%)	1.5	2.0	2.3	9.0	14	30	45	52	67	84	91	100
DOTS notification rate (new and relapse/100 000 pop)	0.5	1.6	1.8	2.9	12	20	38	51	73	94	101	107
DOTS notification rate (new ss+/100 000 pop)	0.2	0.6	0.8	1.2	5.2	9.1	17	23	33	42	45	48
DOTS case detection rate (all new cases, %)	0.3	0.9	1.0	1.6	6.5	11	22	28	41	53	56	59
DOTS case detection rate (new ss+, %)	0.3	0.8	1.0	1.6	6.8	12	23	30	43	55	59	64
Case detection rate within DOTS areas (new ss+, %)[e]	19	42	45	18	51	40	51	58	64	66	65	64
DOTS treatment success (new ss+, %)	79	79	82	84	82	84	85	87	86	86	86	–
DOTS re-treatment success (ss+, %)	70	67	65	72	69	71	69	72	70	73	71	–

INDIA

FINANCING THE STOP TB STRATEGY

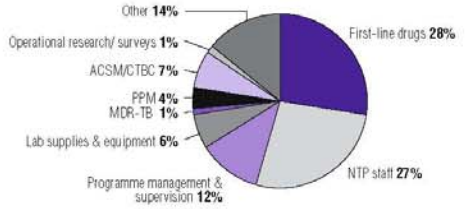
NTP budget by source of funding

Large increase in budget after 2005, which has been fully funded mainly by increasing funding from a World Bank loan and the Global Fund



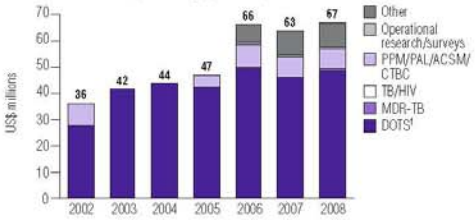
NTP budget by line item, 2008

65% of the budget is for component 1 of the Stop TB Strategy (DOTS expansion and enhancement); the budget for MDR-TB is small – plans for treatment of MDR-TB cover less than 1% of estimated cases



NTP budget by line item

DOTS continues to be a dominant component of the NTP budget, although amounts for other elements of the Stop TB Strategy, particularly PPM, have increased since 2005

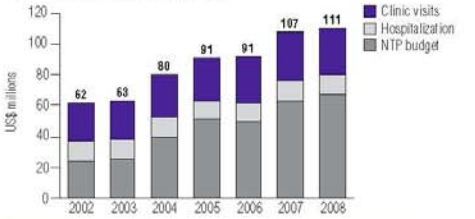


NTP funding gap by line item

No funding gaps have been reported for TB control since 2002

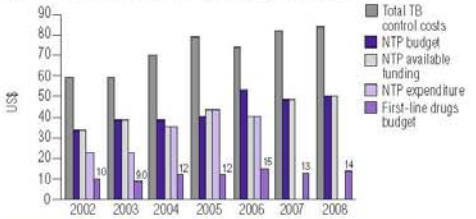
Total TB control costs by line item[5]

Hospitalization costs are for 11 750 dedicated TB beds, costs for clinic visits based on 75% patients using health facilities for DOT



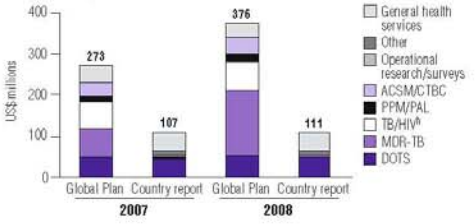
Per patient costs, budgets and expenditures[6]

Increasing cost per patient since 2002 as newer elements of TB control are introduced, but India remains the country with the lowest cost per patient treated among all HBCs



Comparison of country report and Global Plan:[3] total TB control costs, 2007–2008

Targets for MDR-TB patients to be treated in Global MDR/XDR Response Plan much higher than scaling up planned by NTP; NTP budget for TB/HIV small since most activities funded through HIV budgets; ACSM estimates in Global Plan used evidence from outside India



NTP budget and funding gap by Stop TB Strategy component

	2007		2008	
(US$ millions)	BUDGET	GAP	BUDGET	GAP
DOTS expansion and enhancement	46	0	48	0
TB/HIV, MDR-TB and other challenges	0.05	0	0.7	0
Health system strengthening	0	0	0	0
Engage all care providers	3.1	0	2.7	0
People with TB, and communities	4.6	0	4.6	0
Research	1.0	0	0.9	0
Other	9.0	0	9.5	0

Financial indicators for TB

Government contribution to NTP budget (including loans)	56%	58%
Government contribution to total cost TB control (including loans)	74%	74%
NTP budget funded	100%	100%
Per capita health financial indicators (US$)		
NTP budget per capita	0.1	0.1
Total costs for TB control per capita	0.1	0.1
Funding gap per capita	0	0
Government health expenditure per capita (2004)	5.4	
Total health expenditure per capita (2004)	31	

SOURCES, METHODS AND ABBREVIATIONS

a–h Please see footnotes page 169.

1 Incidence, prevalence and mortality estimates include patients infected with HIV. Estimate of ss+ incidence based on 3-year national tuberculin survey completed during 2003 (Chadha, VK. Tuberculosis epidemiology in India: a review. *International Journal of Tuberculosis and Lung Disease*, 2005, 9:1072–1082). Estimates of ss+ prevalence from Gopi PG et al. Estimation of burden of tuberculosis in India for the year 2000. *Indian Journal of Medical Research*, 2005, 122:243–249. WHO estimate of total prevalence of TB (458/100 000 pop in year 2000) is lower than that derived directly from survey (846/100 000 pop). Incidence rate assumed to be constant in absence of contrary evidence, but estimated prevalence and mortality rates decline with growing proportion of cases treated.

2 MDG and STB Partnership indicators shown in bold. Targets are 70% case detection of smear-positive cases under DOTS, 85% treatment success, to ensure that the incidence rate is falling by 2015, and to reduce incidence rates and halve 1990 prevalence and mortality rates by 2015. Estimates for 1990 are prevalence 568/100 000 pop and mortality 42/100 000 pop/yr.

3 The population estimate used by the NTP is lower than that used here and gives a notification rate for new smear-positive cases of 50 per 100 000 population, and a smear-positive case detection rate of 66%.

4 For routine diagnosis, there should be at least one laboratory providing smear microscopy per 100 000 population. By 2009, the RNTCP plans to have established a network of at least 24 state-level accredited laboratories with quality-controlled culture and DST facilities in order to meet the requirements of the programme, including the routine management of MDR-TB.

5 Total TB control costs for 2002–2006 are based on expenditure, whereas those for 2007–2008 are based on budgets. Estimates of the costs of clinic visits and hospitalization are WHO estimates based on data provided by the NTP and from other sources. See Methods for further details.

6 NTP available funding for 2004–2006 is based on the amount of funding actually received, using retrospective data; available funding for 2002–2003 and 2007–2008 is based on prospectively reported budget data, and estimated as the total budget minus any reported funding gap.

– indicates not available; pop, population; ss+, sputum smear-positive; ss–, sputum smear-negative pulmonary; unk, pulmonary – sputum smear not done or result unknown; yr, year.

COUNTRY PROFILE

Russian Federation

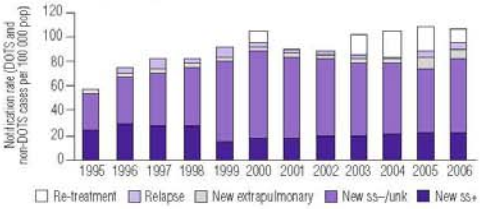
Despite a high nominal DOTS coverage in the Russian Federation, the case detection rate under DOTS remains low, particularly for smear-positive cases. Death, defaulting and treatment failure contribute almost equally to the very low treatment success rate. Plans to provide second-line treatment to 24 000 MDR-TB patients in 2007 and in 2008 (up from 4000 in 2006) are not yet fully funded. In order to implement these plans, the NTP will need to train the appropriate staff, ensure a high-quality laboratory service and a secure supply of second-line drugs. If successfully implemented, they will make a significant contribution to improving the welfare of people with TB in the Russian Federation and in reducing the further spread of MDR-TB.

SURVEILLANCE AND EPIDEMIOLOGY, 2006

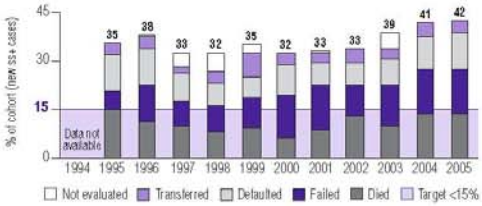
Population (thousands)[a]	143 221
Estimates of epidemiological burden[1]	
Incidence (all cases/100 000 pop/yr)	107
Trend in incidence rate (%/yr, 2005–2006)[2]	**0.7**
Incidence (ss+/100 000 pop/yr)	48
Prevalence (all cases/100 000 pop)[2]	**125**
Mortality (deaths/100 000 pop/yr)[2]	**17**
Of new TB cases, % HIV+[b]	*3.8*
Of new TB cases, % MDR-TB[c]	*13*
Of previously treated TB cases, % MDR-TB[c]	*49*
Surveillance and DOTS implementation	
Notification rate (new and relapse/100 000 pop/yr)	87
Notification rate (new ss+/100 000 pop/yr)	23
DOTS case detection rate (new ss+, %)	**44**
DOTS treatment success (new ss+, 2005 cohort, %)	**58**
Of new pulmonary cases notified under DOTS, % ss+	35
Of new cases notified under DOTS, % extrapulmonary	10
Of new ss+ cases notified, % in women (DOTS and non-DOTS)	26
Of sub-national reports expected, % received at next reporting level[d]	100
Laboratory services[3]	
Number of laboratories performing smear microscopy	4 953
Number of laboratories performing culture	978
Number of laboratories performing DST	302
Of laboratories performing smear microscopy, % covered by EQA	20
Management of MDR-TB	
Of new cases notified, % receiving DST at start of treatment	20
Of new cases receiving DST at start of treatment, % MDR-TB	11
Of re-treatment cases notified, % receiving DST	20
Of re-treatment cases receiving DST, % MDR-TB	23
Collaborative TB/HIV activities	
National policy of counselling and testing TB patients for HIV?	Yes (to all patients)
National surveillance system for HIV-infection in TB patients?	Yes
Of TB patients (new and re-treatment) notified, % tested for HIV	57
Of TB patients tested for HIV, % HIV+	2.3
Of HIV+ TB patients detected, % receiving CPT	–
Of HIV+ TB patients detected, % receiving ART	–

WHO European Region (EUR)
Rank based on estimated number of incident cases (all forms) in 2006

Case notifications
Very high proportion of ss– notifications among new cases suggests under-use of microscopy for diagnosis; high and variable proportion of re-treatment cases



Unfavourable treatment outcomes, DOTS
Death, treatment failure and default rates all continue to be high and contribute to low treatment success rate



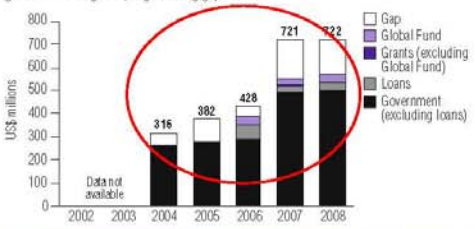
DOTS expansion and enhancement	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
DOTS coverage (%)	–	2.3	2.3	5.0	5.0	12	16	25	25	45	83	84
DOTS notification rate (new and relapse/100 000 pop)	–	0.6	1.2	1.2	2.6	7.7	9.9	12	14	24	57	72
DOTS notification rate (new ss+/100 000 pop)	–	0.2	0.4	0.5	0.9	2.5	2.8	3.5	4.4	6.9	16	21
DOTS case detection rate (all new cases, %)	–	0.7	1.2	1.1	2.3	6.4	8.3	11	13	21	50	63
DOTS case detection rate (new ss+, %)	–	0.5	1.0	1.0	1.8	4.9	5.6	7.4	9.3	15	33	44
Case detection rate within DOTS areas (new ss+, %)[e]	–	21	45	20	36	41	35	29	37	32	40	53
DOTS treatment success (new ss+, %)	65	62	67	68	65	68	67	67	61	59	58	–
DOTS re-treatment success (ss+, %)	58	64	–	49	45	49	48	46	45	34	31	–

RUSSIAN FEDERATION

FINANCING THE STOP TB STRATEGY

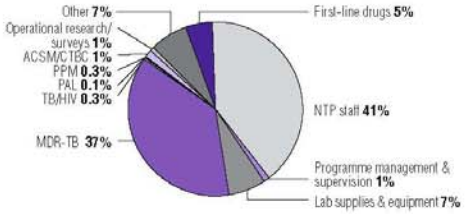
NTP budget by source of funding

Substantial increase in funding needs in 2007 and 2008; while funding from the government has grown, large funding gaps remain



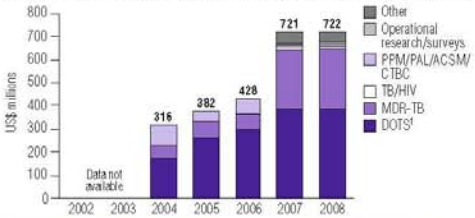
NTP budget by line item, 2008

The largest share of the budget is for dedicated NTP staff and MDR-TB



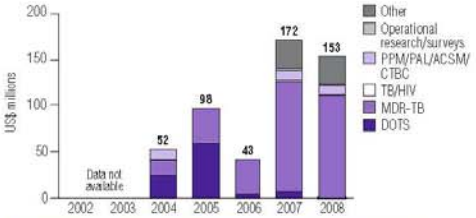
NTP budget by line item

Large increase in funding needs for MDR-TB 2007–2008, to cover treatment for 24 000 MDR-TB patients in each year; cost per MDR-TB patient for second-line drugs US$ 11 000



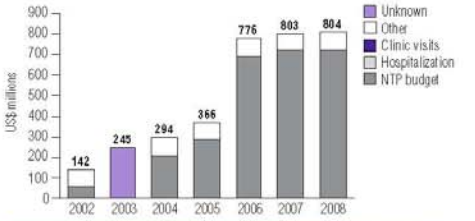
NTP funding gap by line item

Persistent and large funding gaps for second-line drugs since 2004



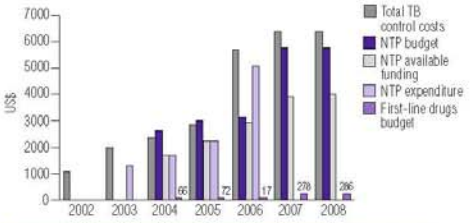
Total TB control costs by line item[4]

Hospitalization costs are for about 80 000 dedicated TB beds



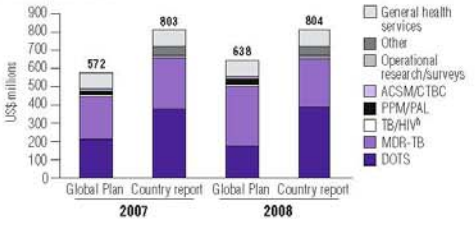
Per patient costs, budgets and expenditures[5]

Increasing cost, budget and expenditure per patient, highest costs and budget among all HBCs; increasing budget for first-line drugs per patient



Comparison of country report and Global Plan:[3] total TB control costs, 2007–2008

Cost of country report far exceeds costs estimated in Global Plan; targets for MDR-TB patients to be treated in country report, as well as costs, similar to those in Global MDR/ XDR Response Plan



NTP budget and funding gap by Stop TB Strategy component

	2007		2008	
(US$ millions)	BUDGET	GAP	BUDGET	GAP
DOTS expansion and enhancement	383	6.4	384	0.8
TB/HIV, MDR-TB and other challenges	269	122	269	112
Health system strengthening	1.0	0.7	1.0	0.7
Engage all care providers	2.0	1.5	2.0	1.4
People with TB, and communities	10	7.4	10	6.9
Research	5.0	2.1	5.0	1.7
Other	51	32	51	30

Financial indicators for TB

Government contribution to NTP budget (including loans)	72%	74%
Government contribution to total cost of TB control (including loans)	75%	77%
NTP budget funded	76%	79%
Per capita health financial indicators (US$)		
NTP budget per capita	5.1	5.1
Total costs for TB control per capita	5.7	5.7
Funding gap per capita	1.2	1.1
Government health expenditure per capita (2004)	150	
Total health expenditure per capita (2004)	245	

SOURCES, METHODS AND ABBREVIATIONS

[a–b] Please see footnotes page 169.

1. Incidence, prevalence and mortality estimates include patients infected with HIV. Incidence estimates based on the assumption that 78% of cases (new and relapse) were detected in 1995 (DOTS and non-DOTS). Moving average of notification rate (new and relapse, DOTS and non-DOTS combined) used as trend in incidence.
2. MDG and STB Partnership indicators shown in bold. Targets are 70% case detection of smear-positive cases under DOTS, 85% treatment success, to ensure that the incidence rate is falling by 2015, and to reduce incidence rates and halve 1990 prevalence and mortality rates by 2015. Estimates for 1990 are prevalence 82/100 000 pop and mortality 10/100 000 pop/yr.
3. For routine diagnosis, there should be at least one laboratory providing smear microscopy per 100 000 population. To provide culture for diagnosis of paediatric, extrapulmonary and ss-/HIV+ TB, as well as DST for re-treatment and failure cases, there should be at least one culture facility and one DST facility in each of the 88 oblasts and equivalent administrative regions.
4. Total TB control costs for 2002–2006 are based on expenditure, whereas those for 2007–2008 are based on budgets. Estimates of the costs of clinic visits and hospitalization are WHO estimates based on data provided by the NTP and from other sources. See Methods for further details.
5. NTP available funding for 2004–2006 is based on the amount of funding actually received, using retrospective data; available funding for 2002–2003 and 2007–2008 is based on prospectively reported budget data, and estimated as the total budget minus any reported funding gap.

– indicates not available, pop, population; ss+, sputum smear-positive; ss–, sputum smear-negative pulmonary; unk, pulmonary – sputum smear not done or result unknown; yr, year.

COUNTRY PROFILE

South Africa

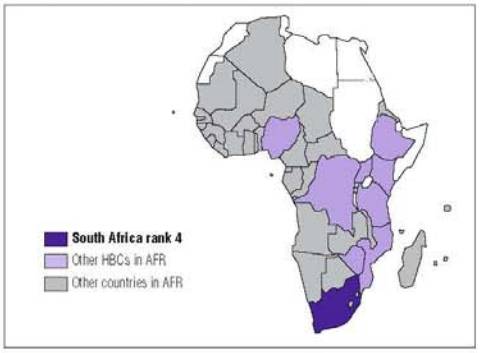
Treatment success rates in South Africa remain low, with death and default the most frequent negative outcomes. Case notification rates continue to increase; a reassessment of the incidence estimate, based on registered deaths, suggests that the 70% case detection rate target was reached for the first time in 2006. Activities related to HIV/TB and MDR-TB are being scaled up, but in 2006 only one third of TB patients were tested for HIV, and information about the number tested for MDR is not available to the NTP. A dramatic increase in funding is expected for 2007 and 2008, principally for investment in infrastructure associated with MDR-TB and XDR-TB.

SURVEILLANCE AND EPIDEMIOLOGY, 2006

Population (thousands)[a]	48 282
Estimates of epidemiological burden[1]	
Incidence (all cases/100 000 pop/yr)	940
Trend in incidence rate (%/yr, 2005–2006)[2]	**1.6**
Incidence (ss+/100 000 pop/yr)	382
Prevalence (all cases/100 000 pop)[2]	**998**
Mortality (deaths/100 000 pop/yr)[2]	**218**
Of new TB cases, % HIV+[b]	*44*
Of new TB cases, % MDR-TB (2002)[c]	1.8
Of previously treated TB cases, % MDR-TB (2002)[c]	6.7
Surveillance and DOTS implementation	
Notification rate (new and relapse/100 000 pop/yr)	628
Notification rate (new ss+/100 000 pop/yr)	272
DOTS case detection rate (new ss+, %)	**71**
DOTS treatment success (new ss+, 2005 cohort, %)	**71**
Of new pulmonary cases notified under DOTS, % ss+	58
Of new cases notified under DOTS, % extrapulmonary	18
Of new ss+ cases notified under DOTS, % in women	45
Of sub-national reports expected, % received at next reporting level[d]	100
Laboratory services[3]	
Number of laboratories performing smear microscopy	143
Number of laboratories performing culture	13
Number of laboratories performing DST	8
Of laboratories performing smear microscopy, % covered by EQA	100
Management of MDR-TB	
Of new cases notified, % receiving DST at start of treatment	–
Of new cases receiving DST at start of treatment, % MDR-TB	–
Of re-treatment cases notified, % receiving DST	–
Of re-treatment cases receiving DST, % MDR-TB	–
Collaborative TB/HIV activities	
National policy of counselling and testing TB patients for HIV?	Yes (to all patients)
National surveillance system for HIV-infection in TB patients?	No
Of TB patients (new and re-treatment) notified, % tested for HIV	32
Of TB patients tested for HIV, % HIV+	53
Of HIV+ TB patients detected, % receiving CPT	98
Of HIV+ TB patients detected, % receiving ART	40

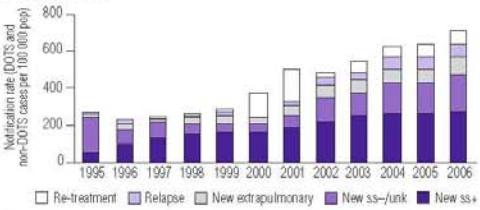
WHO Africa Region (AFR)

Rank based on estimated number of incident cases (all forms) in 2006



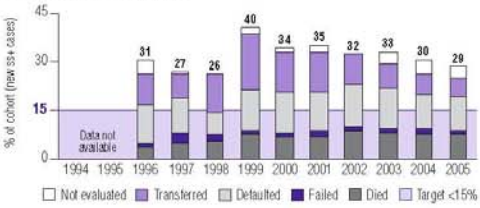
Case notifications

Notifications continue to rise; relapse and re-treatment cases comprise about 20% of total notifications



Unfavourable treatment outcomes, DOTS

Treatment outcomes gradually improving; default still main barrier to reaching the target for treatment success



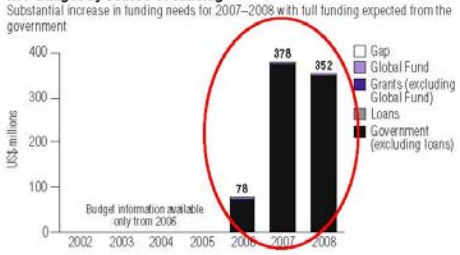
DOTS expansion and enhancement	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
DOTS coverage (%)	–	0.0	13	22	66	77	77	98	100	93	94	100
DOTS notification rate (new and relapse/100 000 pop)	–	–	15	50	202	193	263	456	489	548	543	628
DOTS notification rate (new ss+/100 000 pop)	–	–	9.6	37	122	137	156	210	247	254	250	272
DOTS case detection rate (all new cases, %)	–	0.0	3.7	11	38	34	36	52	52	54	52	60
DOTS case detection rate (new ss+, %)	–	–	6.3	22	61	58	56	66	71	70	67	71
Case detection rate within DOTS areas (new ss+, %)[e]	–	–	49	99	93	75	72	67	72	75	71	71
DOTS treatment success (new ss+, %)	–	69	73	74	60	66	65	68	67	70	71	–
DOTS re-treatment success (ss+, %)	–	67	68	71	47	52	53	53	52	56	58	–

SOUTH AFRICA

FINANCING THE STOP TB STRATEGY

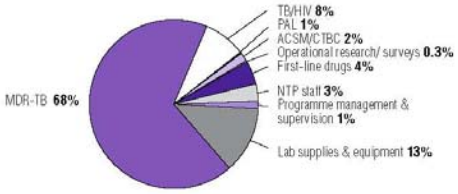
NTP budget by source of funding

Substantial increase in funding needs for 2007–2008 with full funding expected from the government



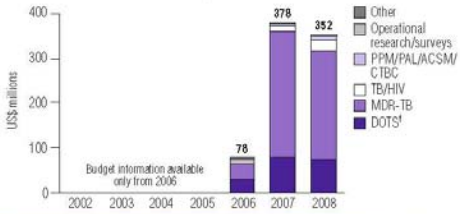
NTP budget by line item, 2008

By far the largest share of the budget is for diagnosis and treatment of MDR-TB



NTP budget by line item

Enormous increase in budget for 2007–2008, mainly for investments in hospital infrastructure for MDR-TB and XDR-TB patients

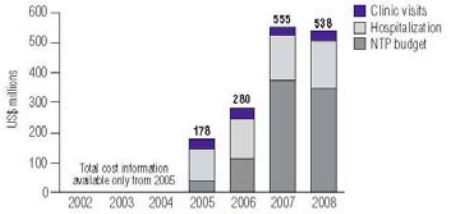


NTP funding gap by line item

No funding gaps have been reported since 2006

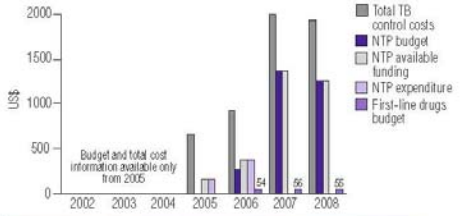
Total TB control costs by line item[4]

NTP budget will account for largest share of TB control costs in 2007–2008 if MDR-TB activities and capital investments are implemented as planned



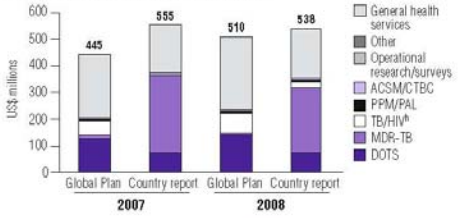
Per patient costs, budgets and expenditures[5]

Highest cost for TB control per patient in Africa



Comparison of country report and Global Plan: total TB control costs, 2007–2008

Projected number of new patients to be treated 2007–2008 higher in Global Plan, therefore higher budget for DOTS; much larger investment in MDR-TB in country plan mainly due to national policy to hospitalize patients for at least 6 months and associated need for renovation and expansion of hospital infrastructure



NTP budget and funding gap by Stop TB Strategy component

	2007		2008	
(US$ millions)	BUDGET	GAP	BUDGET	GAP
DOTS expansion and enhancement	78	0	77	0
TB/HIV, MDR-TB and other challenges	294	0	267	0
Health system strengthening	0.9	0	1.8	0
Engage all care providers	0	0	0	0
People with TB, and communities	2.9	0	5.5	0
Research	2.3	0	1.1	0
Other	0	0	0	0

Financial indicators for TB

Government contribution to NTP budget (including loans)	100%	99%
Government contribution to total cost of TB control (including loans)	100%	100%
NTP budget funded	100%	100%
Per capita health financial indicators (US$)		
NTP budget per capita	7.9	7.4
Total costs for TB control per capita	12	11
Funding gap per capita	0	0
Government health expenditure per capita (2004)	158	
Total health expenditure per capita (2004)	390	

SOURCES, METHODS AND ABBREVIATIONS

a–h Please see footnotes page 169.

1 Incidence, prevalence and mortality estimates include patients infected with HIV. Estimates revised in 2006 following analysis of TB mortality data from vital registration system for years 1997–2005. Incidence pre-1997 and post-2005 estimated extrapolated using logistic curve fitted to 1997–2005 estimates.

2 MDG and STB Partnership indicators shown in bold. Targets are 70% case detection of smear-positive cases under DOTS, 85% treatment success, to ensure that the incidence rate is falling by 2015, and to reduce incidence rates and halve 1990 prevalence and mortality rates by 2015. Estimates for 1990 are prevalence 774/100 000 pop and mortality 76/100 000 pop/yr.

3 To ensure adequate laboratory services coverage there should be at least one laboratory providing smear microscopy per 100 000 population, one culture facility per 5 million population and one DST facility per 10 million population.

4 Total TB control costs for 2005–2006 are based on expenditure, whereas those for 2007–2008 are based on budgets. Estimates of the costs of clinic visits and hospitalization are WHO estimates based on data provided by the NTP and from other sources. See Methods for further details.

5 NTP available funding for 2005–2006 is based on the amount of funding actually received, using retrospective data; available funding for 2007–2008 is based on prospectively reported budget data, and estimated as the total budget minus any reported funding gap.

– indicates not available; pop, population; ss+, sputum smear-positive; ss–, sputum smear-negative pulmonary; unk, pulmonary – sputum smear not done or result unknown; yr, year.

Annex J. World Bank Investment Lending for TB

At the country level, World Bank support to TB control started in 1991 in China, with a large project to control both TB and schistosomiasis. The project, which introduced the DOTS approach in half of China's provinces, is considered a major success, and has provided excellent data for assessing its impact. An article published in the Lancet concludes that "[t]his project in China has successfully diagnosed, treated, and cured more cases of tuberculosis than any other DOTS programme to date [sic!]."[33] A subsequent project in Vietnam in 1995 built on this success. Consequently during the 1990s, the World Bank was internationally seen as the largest and most influential financial player in TB control.

In the 1990s, the Bank increasingly supported projects to control communicable diseases, in line with a major policy focus on support for global public goods. Of these communicable diseases, TB has been one of only four that were targeted by more than one single-disease control project — justified by the fact that it kills 1.6 million people annually as well as by its severe economic impact.[34] Nevertheless, the major driver for this focus on communicable diseases has been the HIV/AIDS pandemic. Consequently HIV/AIDS projects (MAP projects) account for about 85 percent of all communicable disease projects between 1997 and 2006.

A recent IEG evaluation (covering 1997–2006) shows that Bank support for communicable diseases has produced demonstrable results, in general. In TB control, the interventions have benefited from a thorough understanding of the disease's epidemiology and of its socio-economic implications, which has been translated into effective policies and strategies (such as DOTS) with clear and measurable objectives. (This unfortunately was not the case for many HIV/AIDS operations, which, due to the complexity of this disease, not surprisingly produced more modest results.[35])

Between 1997 and 2006, there have been five major TB control operations supported by the Bank: two single-disease projects in India and China, as well as three multiple-disease projects in Argentina, Ukraine and the Russian Federation. All these projects provided financial support in the range of US$100 million or more to the respective governments. Some are repeater projects — for example, the China TB control project is a continuation of the previous successful endemic disease project — or are likely to be follow-up projects, as planned in India.

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33. China Tuberculosis Control Collaboration, "The Effect of Tuberculosis Control in China," *Lancet* 364, 417–422, 2004. The authors further "estimate that in 2000, in a population of more than half a billion, there were 382,000 fewer prevalent culture-positive cases and 280,000 fewer prevalent smear-positive cases than there would otherwise have been", 417.

34. Ramanan Laxminarayan et al., *Economic Benefit of Tuberculosis Control*, Washington DC: The World Bank, Policy Research Working Paper 4295, 2007.

35. Paul Webster, 2002, "Agreement Unlocks Loan for TB and AIDS Treatment in Russia," *Science* 297, 170.

The project in the Russian Federation (2002–2008) is particularly noteworthy. Development of a TB control project (later accompanied by HIV/AIDS) with the Ministries of Health and Justice began in 1999. In the course of intensive and time-consuming high-

Annex Table 5. World Bank Projects Targeting TB, 1997–2007

Project Name	Country	Project Design	Disease	Approval Year
(a) Single-Disease / Major Component				
Tuberculosis Control Project	India	Single-Disease	Tuberculosis	1997
Tuberculosis Control	China	Single-Disease	Tuberculosis	2001
Public Health Surveillance and Disease Control Project	Argentina	Multiple Disease	Endemic Diseases	2000
Tuberculosis and HIV/AIDS Control Project	Ukraine	Multiple Disease	AIDS, Tuberculosis	2001
Tuberculosis and AIDS Control Project	Russian Federation	Multiple Disease	AIDS, Tuberculosis	2003
Health Restructuring Project	Kazakhstan	Communicable Disease Component	Tuberculosis	1999
(b) Substantial Component				
HIV/AIDS, Malaria, STD and TB (HAMSET) Control Project	Eritrea	Multiple Disease	AIDS, Malaria, Tuberculosis	2001
HIV/AIDS, Malaria, and TB Control Project (HAMSET)	Angola	Multiple Disease	AIDS, Malaria, Tuberculosis	2005
HIV/AIDS/STI, TB, Malaria, and Reproductive Health Project (HAMSET II)	Eritrea	Multiple Disease	AIDS, Malaria, Tuberculosis	2005
(c) Minor Components / Technical Assistance Element				
Disease Control and Health Development Project	Cambodia	Communicable Disease Component	AIDS, Malaria, Tuberculosis	1997
Second Health Sector Support Project	Madagascar	Communicable Disease Component	AIDS, Malaria, Tuberculosis	1999
HIV/AIDS, Malaria, and Tuberculosis Control Project	Djibouti	Multiple Disease	AIDS, Malaria, Tuberculosis	2003
HIV/AIDS Capacity Building and Technical Assistance	Lesotho	Multiple Disease	AIDS, Malaria, Tuberculosis	2004
Total War against HIV/AIDS	Kenya	Single-disease	AIDS	2007

Source: G. Martin, *Portfolio Review of World Bank Lending for Communicable Disease Control,* Background Paper for the IEG Evaluation of World Bank Support for Health, Nutrition and Population, 2009. The 2007 project in Kenya has been added by author.

level policy dialogue, which extended over almost four years and involved analytical work and co-sponsored training of government officials, the Bank was able to aid the Russian TB program in increasing its effectiveness. In particular, the Bank was able to convince Russian authorities about the merits of adopting the globally endorsed DOTS strategy; building the capacity of Russian drug manufacturers; and highlighting the need of judicial reform to reduce transmission of TB in prisons. These negotiations and the successful implementation

of the project required not only technical expertise but also diplomatic skills of three consecutive Bank project managers.

However, there are no single-disease and astonishingly few projects with TB components in the Africa portfolio — in contrast to the success of TB control in Asia and in countries of the former CIS. Furthermore this review has found that almost none of the MAP HIV/AIDS projects in Africa contain specific financial support for tuberculosis control. This is surprising — and a vital opportunity has been largely missed in Africa — as the strong links between HIV/AIDS and TB are well established. The risk for people living with AIDS acquiring tuberculosis is about 100 times greater than in the general population and represents their leading cause of death.[36] While there are small TB components in five projects in Africa (e.g., there is some funding for anti-tuberculosis drugs in Madagascar or institutional support to facilitate funding from the Global Fund), Eritrea and Angola are the only two countries in sub-Saharan Africa that receive substantial financial support from the Bank for integrated HIV/AIDS and TB control through HAMSET projects. Even the recent (2007) "Total War against HIV/AIDS" project in Kenya allocates only 5 percent of Bank financing to TB drug procurement, as compared to more than 10 percent for "accountability and verification" as part of strengthening governance in the AIDS sub-sector.

The lack of attention to TB in the Bank's Africa health portfolio has not gone unnoticed, both internally and externally. Civil society groups have pointed out this gap — with reports and with critical public statements. This was followed in 2007/08 by a "pre-printed postcard campaign" addressed to World Bank President Zoellick urging the Bank to pay more attention to TB in Africa. In response, some efforts have been undertaken by the Bank to respond to the criticism: a "focal point" for TB in the Region has been appointed, and substantive and more informative material on the Bank's role in TB control has been made available. One major TB-related operation is planned in Africa so far; this will be a regional laboratory-improvement project in the southern cone of Africa, focusing on the rapidly emerging threat to public health due to drug-resistant and "extremely-drug-resistant" TB. In 2009, the Bank's Institutional Development Fund made a grant to the Medical Research Council in South Africa to improve quality-assured TB diagnostic services in the region.

Also, in response to the external criticism, Bank management in the Africa region has pointed to the relative small size of countries, which make single-disease projects difficult due to their high preparation and implementation costs, and the limited IDA funding available for health sector operations. Only one project is planned every few years for the smaller countries; but there is an increasingly more important focus on sector-wide approaches (SWAp) in the health sector. The health policy framework for the Africa Region — as is pointed out repeatedly in various Bank documents — has primarily emphasized the strengthening of health systems and the subsequent anticipated integration of TB activities with primary health care. While this approach might be conceptually attractive, the intended integration of TB control with other health sector activities has simply not occurred on the ground. Furthermore, in contrast to TB control, diseases such as HIV and Malaria are treated as categorical programs in the Bank's Africa portfolio, thus further exacerbating the imbalance.

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36. RESULTS International, *Enduring Neglect. The World Bank's Inadequate Support for Africa's TB Emergency,* Washington DC, 2006.

Annex K. Partnership Financing

Annex Table 6. Financing: Stop TB Secretariat, Excluding the Global Drug Facility (US$ '000)

	2001	2002	2003	2004	2005	2006	2007	2008
Income								
Voluntary Contributions in Cash								
Governments and Their Agencies	3,068	2,967	4,360	6,885	3,774	9,545	18,820	12,885
CIDA				2,736	351	0		
DFID				1,815	176	5,870 /1		
USAID/CDC				927	822	1,609		
The Netherlands						1,839		
Other				1,407	2,425	227		
Multilateral Organizations and Foundations	1,020	1,048	75	728	1,170	2,759 /2	3,333	2,829
Interest Income			0	0	0	1,280	1,578	1017
Total Cash Contributions	4,088	4,015	4,435	7,613	4,944	13,584	23,731	16,731
Voluntary In-Kind Contributions								
Governments	378	535	213	213	169	13		
Multilateral Organizations and Foundations			595	443	359	379	451	200
Sub-Total			808	656	528	392	451	200
Total Income	4,466	4,550	5,243	8,269	5,472	13,976	24,182	16,931
Expenditures								
Partnership	1,406	3,473	3,524	2,518	3,211	5,791	13,313	8,517
National partnership coordination				429	300	540		
General partnership management				1,501	606	1,061		
ISAC				0	1,312	442		
Governance				100	470	725		
Working Groups				488	523	774		
Technical assistance India						2,249 /1		
Advocacy and Communication	538	1,036	855	1,096	929	1,093	2,566	3,278
General Management and Administration (and % of total) /3	585 (23%)	538 (11%)	898 (17%)	1,251 (26%)	1,173 (22%)	1,374 (17%)	1,644 (9%)	2,610 (18%)
Salaries				620	710	751		
Activities				124	87	48		
WHO professional service charge				481	376	575		
World Bank Service Charge				26	0	0		
Total Expenditure	2,528	5,047	5,277	4,865	5,313	8,258	17,523	14,405
Surplus/Deficit of Income over Expenditure	1,938	-497	-34	3,404	159	5,718	6,659	2,526

Source: Stop TB Partnership Secretariat; 2008 External Evaluation, McKinsey & Co.

/1 This includes $2,392,000 for technical assistance to India.

/2 The Bill and Melinda Gates Foundation gave $1,789,000.

/3 This includes some administrative costs for GDF operations.

Annex Table 7. Financing: Global Drug Facility (US$ '000)

	2001	2002	2003	2004	2005	2006	2007	2008
Income								
Governments and Their Agencies, Specified	15,235	7,933	14,911	15,157	26,085	40,723	59,167	62,032
CIDA				11,347	20,642	22,862		
USAID				3,000	4,700	5,000		
Norway				810	743	899		
DFID						11,962		
Direct Procurement			5,786	6,613	13,433	6,165	12,500	15,463
In-kind contribution of drugs (Novartis)	0	158	0	0	2,605	3,226	2,340	1,033
In-kind contribution of staff			188	188	188	125		
Other			1,249	259	0	0		227
Total	15,235	8,091	22,134	22,216	42,311	50,240	74,007	78,755
Expenditures								
Grant procurement	7,843	10,753	13,626	8,000	28,367	41,344	36,847	52,098
Direct procurement			5,786	6,613	13,433	6,165	12,500	15,463
Quality assurance and pre-qualification	709	281	144	114	123	84	106	140
Technical assistance, monitoring and salaries	672	965	1,255	1,036	1,649	1,875	2,384	3,068
Advocacy and communication	0	80	21	102	57	43	182	231
Indirect costs /[1]	0	0	519 (2.4%)	666 (4.0%)	1,151 (2.6%)	1,366 (2.7%)	893 (1.7%)	982 (1.4%)
Total Expenditures	9,223	13,012	21,351	16,531	44,780	50,877	52,912	71,982
Surplus/Deficit of Income over Expenditure	6,011	-4,921	783	5,685	-2,469	-638	21,095	6,773

/1 This represents a service charge to WHO for drug procurement.

Annex L: Persons Consulted

Person	Position
Stop TB Partnership Secretariat	
Marcos Espinal	Executive Secretary
Robert Matiru	Operations Manager, Global Drug Facility (GDF)
Anant Vijay	Department & Partnership Resource Administrator, Administration & Finance Operations Team
2. WHO Stop TB Department	
Mario Raviglione	Director
Diana Weil	Coordinator, Policy and Strategy
Leopold Blanc	Coordinator, TB Strategy and Health Systems
Paul Nunn	Coordinator, TB-HIV and Drug Resistance
Katherine Floyd	Coordinator, TB Monitoring and Evaluation
3. Others	
Irene Cook	Chair, Coordinating Board USAID
Jaap Broekmans	Chair, Evaluation Steering Committee Executive Director, KNCV
Robert Ridley	Director, TDR, WHO
Lorenzo Savioli	Director, NTD Department, WHO
4. World Bank	
Julian Schweitzer	Director, Health, Nutrition and Population Sector
Olusoji Adeyi	Coordinator
Ok Pannenborg	Senior Advisor
Miriam Schneidman	Senior Health Specialist
Joel Spicer	Senior Health Specialist
Bernard Abeille	Consultant; Former Chief, Procurement – Africa Region
Hiba Thaboub	Lead Procurement Specialist

Annex M. Response of the Program to IEG's Global Program Review

The Global Program Review conducted by the Independent Evaluation Group of the World Bank is much appreciated and will be of help to us as it offers a view from a standard-setting multilateral agency having broad and deep development view.

This review undertaken by IEG reflects an understanding of the Stop TB Partnership, its origins, its growth from a small Partnership to a large one as well as the challenges it faces. It also assesses the independent external evaluation of the Partnership that was submitted by McKinsey & Company in 2008 and supports its findings. We are pleased to note that the current GPR confirms that the stop TB Partnership is one of the best performing global partnerships in the health sector.

The GPR draws a number of lessons for the Partnership and for other global health programs. It brings into relief the success of this Partnership in a number of areas such as (a) being able to develop a shared understanding of the respective roles, responsibilities and commitment of partners, capitalizing on its political know-how to make its efforts globally visible; (b) building a solid relationship with its host agency, the WHO; and (c) its high profile innovative initiatives such as Global Drug Facility (GDF) and the Green Light Committee (GLC).

We find the World Bank's DGF Window 1 grant, though small, very useful. Being flexible, it can be used catalytically to make the much larger specified grants really useful. It would help us immensely if this could be increased.

The GPR report rightly points out that the Bank has been a major institutional player in the Stop TB Partnership. It indicates that the Bank has acquired institutional legitimacy and a positive reputation due to its effective engagement with other Partners during the creation of the Partnership and due to its country-level operations on control of tuberculosis and other infectious diseases. It appropriately recommends that such a positive reputation needs to be actively maintained. In this vein we hope that the World Bank, in line with the recently agreed model Memorandum of Understanding between Governments and WHO for procurement of supplies with World Bank Group funding, shall continue to support the procurement of anti-TB drugs by countries through the GDF with IDA grants or loans. We agree, as the report recommends, that the legitimate differences in the procurement procedures between the World Bank and GDF need to be conclusively dealt with. Resolution of these differences is paramount for substantial IDA funding to flow through GDF.

The Global Program Review Series

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	Issue #2:	Global Development Network
	Issue #3:	Global Forum for Health Research
	Issue #4:	Global Invasive Species Program
Volume #4,	Issue #1:	Stop Tuberculosis Partnership

GPR

The Stop TB Partnership is a network of more than 900 international and national public and private sector organizations and individuals aiming to eliminate tuberculosis (TB) as a public health problem. Located in the World Health Organization in Geneva, it was established in 2001 to foster greater collaboration among international agencies, donors, and governments of endemic countries to meet global TB control targets. A 2008 evaluation by McKinsey & Company concluded that the Partnership has contributed significantly to global efforts to control TB. This review confirms the widely held view that Stop TB is the one of the best performing global partnerships in the health sector, based on an analysis of its relevance, efficacy, efficiency, governance, and management. Yet the sustainability of its achievements will depend not only on the Partnership itself but also on its ability to successfully confront new challenges posed by HIV and drug resistance, on the complementary disease-control activities of its donor partners, and on the capacity of high-burden countries to sustain TB control. The World Bank has been a major institutional player in Stop TB at both the global and country levels. But the protracted amount of time the Bank has taken to enable its client countries to procure drugs with World Bank funds through the Global Drug Facility has reflected negatively on its institutional reputation.

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INDEPENDENT EVALUATION GROUP