Chapter 8

Supporting the Global Plan to Stop TB

1. Building the Partnership—The Stop TB Secretariat

1.1 RATIONALE

The *Global Partnership to Stop TB* has grown rapidly since its launch in November 1998. It now consists of over 200 organizations around the world, all committed to the vision, mission, and objectives of Stop TB, and working together in accordance with the values of the Partnership. Beginning in June 2001, the Secretariat invited partners to submit information on their activities to a directory of Stop TB Partners (www.stoptb.org/Partners_Directory/). Eighty-three partners, including nearly three-quarters of all major institutional partners, have thus far completed an entry. The portrait of the Partnership is presented below in Section 2, drawn from these submissions.*

To support these organizations in the fulfilment of the Partnership's vision and mission, WHO has established a Stop TB Secretariat, staffed by WHO and partner secondments. Many activities of the Secretariat are carried out in collaboration with specific partners.

1.2 OBJECTIVES

The Stop TB Secretariat has four main areas of activity, corresponding to the objectives of partnership strengthening.

*The Partnership has grown considerably since this survey was conducted in June 2001. The eighty-three responses represented a majority of those surveyed.

1.2.1 PARTNERSHIP BUILDING

The Secretariat performs the following partnership-building activities:

- Maintenance of a web-based directory of partners (www.stoptb.org) providing contact details of organizations and identifying geographical and functional areas of interest.
- Organization of meetings of the Coordinating Board and the Partners' Forum, and assistance in organizing meetings of working groups and task forces.
- Development of regional and national partnerships, such as interagency coordinating committees on TB. Frequently, these are cross-cutting coordination mechanisms that serve several aspects of health (for example, vaccination, and HIV/AIDS, and sector-wide approaches).

1.2.2 INFORMATION AND COMMUNICATIONS

The Secretariat performs the following information and communications activities:

- Dissemination of pertinent information by e-mail, Internet, publications, and other means.
- Maintenance of the database of TB-related information for the Partnership.

1.2.3 ADVOCACY

In collaboration with other partners, the Secretariat:

- develops TB-related advocacy messages;
- organizes and coordinates World TB Day activities; and
- assists partners and countries in implementing local advocacy activities.

1.2.4 RESOURCE MOBILIZATION

In collaboration with the Stop TB Coordinating Board and other partners, the Secretariat:

- implements the resource mobilization plan for the Partnership; and
- develops financing mechanisms for the Partnership.

In addition to these activities, the Secretariat also functions as the Secretariat for the Global TB Drug Facility, managing and/or coordinating processes relating to country applications, procurement of drugs, and monitoring.

1.2.5 GLOBAL TB DRUG FACILITY

The Stop TB Secretariat also functions as Secretariat for the Global TB Drug Facility (GDF)—a new initiative of the Stop TB Partnership to increase access to high-quality TB drugs. Launched in early 2001 with funding from the Canadian government, and housed in WHO, the GDF aims to treat more than 10 million people with TB by 2005, in support of the global targets for DOTS expansion. The role of the GDF Secretariat is to manage processes relating to applications and review, procurement of drugs, and monitoring. These different functions are carried out by different partners and are coordinated by the GDF Secretariat, through contracts and agreements.

The GDF has already had a significant impact. Two rounds of applications have been reviewed, with 25 countries submitting applications by December 2001. Of these, 16 had been approved

for support, and drugs ordered for over 630,000 patients. Pooled procurement, standardisation of products, and international competitive bidding has also had a profound impact on drug prices, with a six-month course of daily treatment now costing less than $10—one-third lower than previous international prices.

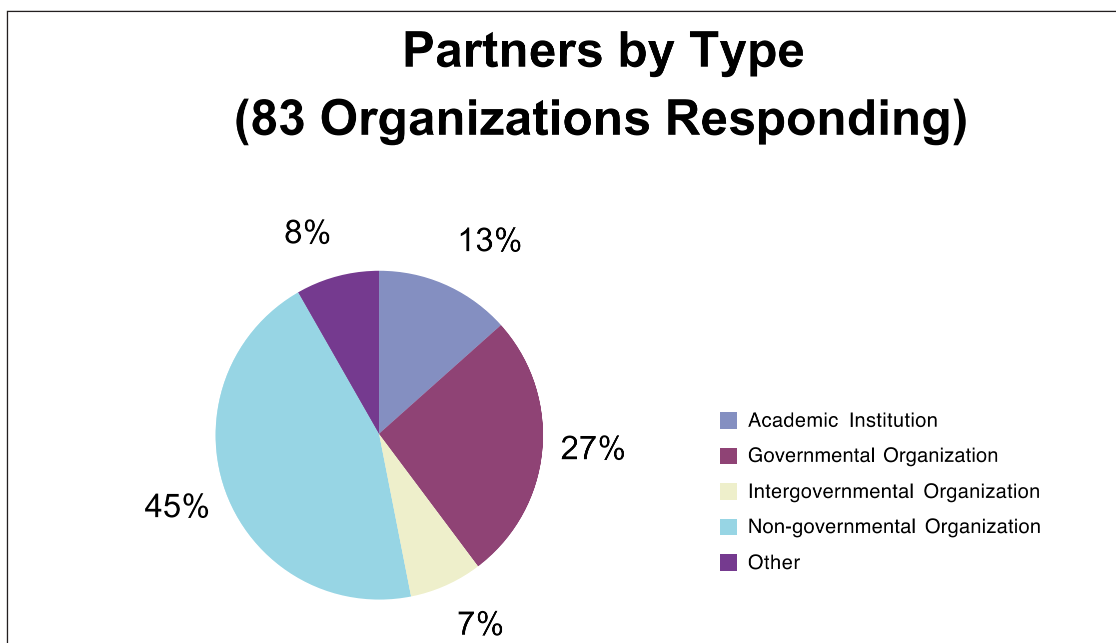
Activity area	Budget 2001 – 2005 ($ millions)*
Partnership building	6
Information and communications	4
Advocacy	10
Resource mobilization	7
Global TB Drug Facility	See DOTS Expansion budget
Total	**27**

**Projected from a two-year budget of the Stop TB Secretariat. Further detail is available from the Secretariat.*

1.3 RESOURCE NEEDS

As of December 2001, known contributions to the Secretariat amounted to some $10 million, leaving a resource gap of $17 million.

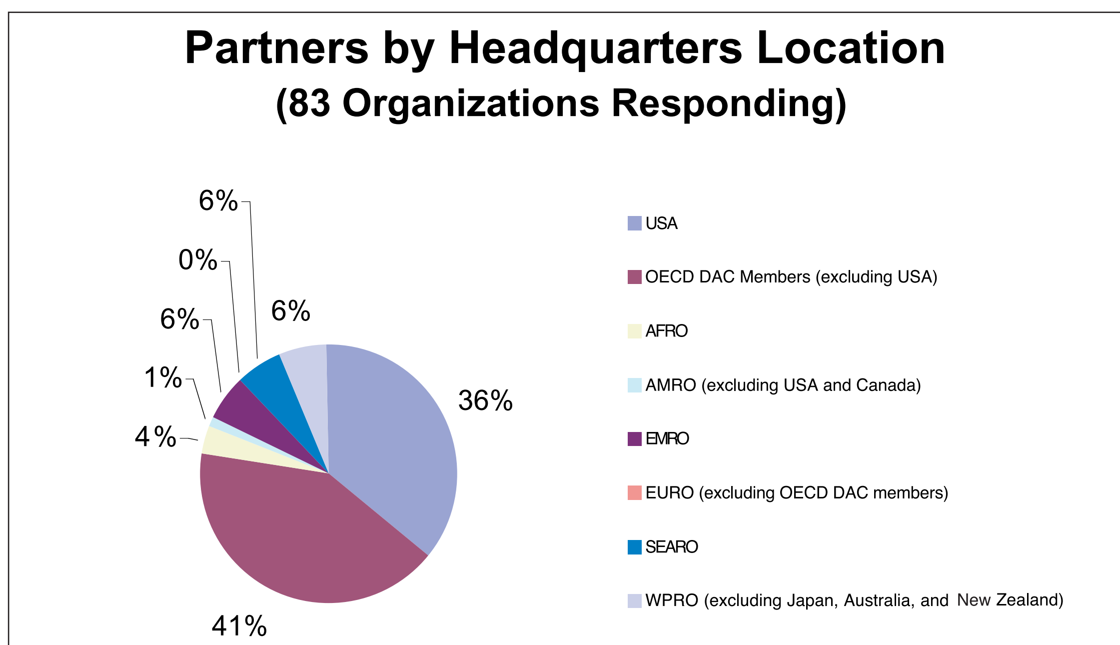
2. Building the Partnership: Who Are the Partners?



The Stop TB Partnership embraces organizations of many types: for-profit corporations; non-governmental organizations (NGOs); governmental public health agencies, both national and sub-national; bilateral aid agencies; multilateral organizations; and others. Nearly half of the respondents to the directory were NGOs. Approximately 25 percent were governmental bodies, split almost evenly between technical and donor agencies.

Partners also vary greatly in the depth and scope of their TB-related work. The number of professional staff working on activities related to TB and the amount spent on TB activities in 2000 were used to gauge the depth of partners' work. Nearly 50 percent of respondents reported five or fewer professional staff working on TB, while 25 percent reported between six and ten. Still, 11 percent of all partner organizations reported more than 20 such staff. Of the 53 partners providing information on expenditures, 25 percent spent less than $100,000; 33 percent spent between $100,000 and $1 million; another 33 percent spent between $1–10 million; and the remainder spent more than $10 million on TB control.

Partners reported on both present and projected work. They reported ongoing work in more than 90 countries. In five countries—Bangladesh, India, the Philippines, Russia, and the United States—five or more partners were reportedly working simultaneously. Twenty-eight countries in the WHO Regional Office for Africa (AFRO) and eight countries in the WHO Regional Office for South-East Asia (SEARO) reported at least one active partner. Regarding projects in the planning stages, 18 partners noted plans for 35 projects in 23 countries, including four new countries—El Salvador, Malawi, Mozambique, and Somalia—where no partners are currently active.



In summation, the Partnership is remarkably diverse as far as the types of organizations it includes and the intensity and scope of their TB efforts. This diversity is regrettably not matched by "geo-economic" diversity. Nearly 80 percent of respondent organizations were headquartered in one of the 21 Organization for Economic Cooperation and Development's (OECD's) Development Assistance Committee (DAC) countries.

Only three respondents to the Stop TB directory were based in AFRO, and only five in SEARO. Doubtless, a significant proportion of partners that did not respond were smaller organizations based in high-burden countries (HBCs), or other low- or middle-income countries. Yet, including both respondents and non-respondents, fully half of all partners are based in the OECD DAC countries.

This imbalance points to the need for the global partnership to encourage and, where necessary, to fund active participation by organizations based in HBCs or other low- and middle-income countries. It also suggests the need for Stop TB to develop strong regional and country-level partnerships, and foreshadows the challenges such an endeavour may involve.

2.1 PARTNERS' WORK IN TB HIGH-BURDEN COUNTRIES

The portrait reported here of Partners' activities is unfortunately not comprehensive, but a partial portrait follows below.

Overview: Twenty-five partners presently work in one or more countries designated as high-burden; there are sixty-nine distinct interventions. Each HBC has at least one partner presently active while nine HBCs, including five of the highest burden countries, have two or fewer. Furthermore, twelve HBCs, including nine of the highest burden countries, now find themselves with meagre prospects for welcoming new partners. For these countries, the number of partners planning future work, combined with the number of partners interested in taking on work given substantially greater resources, was either one or zero.

TB-HIV: Thirteen HBCs had no partners reporting either present or planned work on TB-HIV; a further five HBCs had just one such partner. Among these 18 countries were eight in which more than two percent of adults were estimated to be living with HIV/AIDS at the end of 1999. (These countries include D.R. Congo, Ethiopia, Nigeria, Uganda, and Zimbabwe.) Kenya (three partners) and Russia (four partners) were associated with the most partners working or planning work in this area.

MDR-TB: Thirteen HBCs had no partners reporting either present or planned work on MDR-TB, including most notably Brazil, China, Thailand, and Zimbabwe. A further three countries had just one such partner each. India, with what is likely to be the world's largest number of new MDR-TB cases each year, had two. Russia had six.

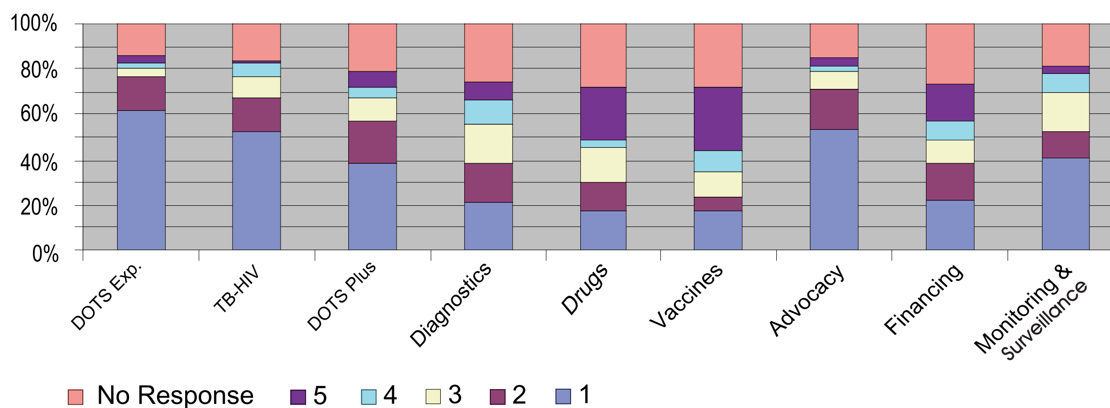
Technical Support: Seventeen HBCs had two or fewer partners reporting either present or planned provision of technical support. Afghanistan, Thailand, Viet Nam, and D.R. Congo had no partners. South Africa, Uganda, and Zimbabwe had just one. India, Indonesia, Nigeria, Pakistan, and Russia had three or more. Others had two.

2.2 WHAT PARTNERS BRING TO THE PARTNERSHIP AND WHAT THEY EXPECT FROM IT

Partners were asked to name the most important things they could bring to the Partnership. Responses were grouped according to type of organization, and tended to cluster predictably within types. That said, some unexpected regularities appeared across types. For instance, intergovernmental and governmental organizations (whether donors or technical agencies)

often cited TB-HIV as an area in which they could bring value to the Partnership. In contrast, NGOs (whether foundations or general/technical organizations) more often stressed advocacy and resource mobilization capabilities.

Partners were also asked to rate their interest in participating in the Partnership's working groups and task forces. They expressed relatively strong interest in the working groups on DOTS Expansion, TB-HIV, and in the newly formed Advocacy and Communications Task Force—but relatively weak interest in the working groups on Drug Development, Vaccine Development, and newly formed Financing Task Force.



Finally, partners were asked to explain what services would be most useful and appreciated from the Partnership and its Secretariat. The two most common responses were remarkably consistent across all organization types. They said that the Partnership (that is, the Secretariat) should serve as:

- a "network hub", facilitating communications among partners and between partners and others, while also serving as a central repository for information about the partners, their activities, and the countries in which they work; and as
- an "information disseminator", propagating research findings, technical guidelines, lessons learned, and best practices; it should also amplify successes of individual partners, both within the Partnership and to the world at large.

3. Supplemental Advocacy and Communications for the Global Partnership to Stop TB

3.1 RATIONALE

Successfully implementing the *Global Plan to Stop TB* will require sustained support, internationally and at national and local levels, especially in the 22 TB high-burden countries.

Advocacy and communications efforts to generate this support must go well beyond the efforts of recent years, and will require support beyond what is currently budgeted by the Stop TB Secretariat. These supplemental efforts will be aimed at three key target audiences: decision-makers, health-sector professionals, and communities.

Health-communication programmes can inform, influence, and motivate these target audiences by increasing awareness of public health problems, the issues they encompass, and the solutions available to resolve them. A good outreach programme will positively affect attitudes towards support and public investment. It can also profile the skills and dedication of those working to control an epidemic as well as increase demand for services, reinforce awareness of supportive behaviour, influence opinions, and encourage attitudes such as optimism, compassion, and commitment.

Stages in the health communication process are as follows:

- planning and selection of strategies to reach specific target audiences;
- developing consistent and compelling messages;
- selecting communication channels and materials;
- developing and pre-testing materials;
- implementing strategies;
- assessing the strategies' effectiveness; and
- incorporating feedback to refine the programme.

To ensure a coordinated approach to advocacy and communication efforts, partners in Stop TB are creating an Advocacy and Communications Task Force. The purpose of this task force is to prioritise, plan, develop, and coordinate advocacy and communications strategies for the Stop TB Partnership, and to support the advocacy and communications activities of partner organizations.

3.2 OBJECTIVES

The objectives of the Advocacy and Communications Task Force are to:

- Identify advocacy and communications priorities for the Global Partnership to Stop TB.
- Plan, organize, and coordinate advocacy and communications activities and events, and develop tools in support of the mission of the Stop TB Partnership and the *Global Plan to Stop TB*.
- Develop consistent and compelling messages and advocacy tools in support of the key objectives of the Stop TB Partnership at both the global and national levels.
- Develop mechanisms to support communication between partners, and provide communications/advocacy assistance to partners, working groups, and other organizations at the country level.
- Develop and implement partnership mechanisms to evaluate the effectiveness of the advocacy and communications efforts of the Stop TB Partnership.

At the global level, the Advocacy and Communications Taskforce will contribute to:

- A stronger TB partnership that is consistent in terms of the messages and information disseminated to promote effective action to stop TB.
- Closely coordinated global advocacy campaigns to promote effective action to stop TB.

- Raising resources necessary to support the work of partners and countries in controlling TB.
- More effective use of existing partner resources, both technical and human, to better serve members and TB-endemic countries.

At the country level, the Advocacy and Communications Task Force will contribute to:

- Heightened awareness of TB-related issues among policy-makers, opinion leaders, and influential groups.
- Increased tendencies among policy-makers to adopt and implement policies and programmes in support of achieving TB-control targets as defined by WHO for 2005, 2010, and beyond.
- Better training and awareness of internationally recommended strategy for TB control on the part of public and private health-care workers, and better compliance with this strategy.
- Increased social mobilization in support of TB control and eventual elimination.

3.3 RESOURCE NEEDS

Early estimates place the supplemental resource needs for advocacy programmes at around $20 million over the next five years. However, this estimate is not yet supported by a detailed budget.

4. Financing the Global Plan to Stop TB

4.1 RATIONALE

The Global Partnership to Stop TB has recognized the need of countries and global programmes for financial and economic capacity, information, and resources. Furthermore, the Partnership is an important part of exciting global developments in finance for disease control. In order to coordinate these activities, the Stop TB Partnership has established a task force on financing.

The purpose of this task force is to identify and resolve challenges in financing TB control and research and development across the Partnership in support of the goals of the *Global Plan to Stop TB*, including health-systems development and poverty reduction.

4.2 OBJECTIVES

The Stop TB Financing Task Force has five main objectives:

1. **To assess TB financing at global, regional, and country levels.** To identify financing needs, existing resources, and gaps for TB control. To assess the utilization of financing and its efficiency.

2. **To improve TB finance.** To identify mechanisms for sustainable financing and strategies for resource mobilization.

3. **To improve financial planning, management and accountability**. To stimulate financial capacity building and mainstreaming of health systems issues.

4. **Priority setting.** To provide guidance to the Coordinating Board on priority-setting mechanisms for the allocation of funds.

5. **To act beyond TB.** Coordinate with broader health-system financing agencies and public health priorities at all levels, including disease control initiatives, such as the Global Fund to Fight AIDS, TB and Malaria, the Global Alliance for Vaccines and Immunizations (GAVI), Roll Back Malaria (RBM), UNAIDS, Poverty Reduction Strategy Papers, Sector Wide Approaches (SWAP), WHO's Evidence and Information for Policy cluster, incentives for new products, and so forth.

4.3 RESOURCE NEEDS

The supplemental resources needed are currently estimated at $12.5 million over the coming five years. However, this estimate is not yet supported by a detailed budget.

5. Setting Priorities

Stop TB Partners will regularly monitor and assess progress in reducing the burden of TB and in meeting the principal objectives of the *Global Plan to Stop TB*. The Stop TB Coordinating Board will want to promote particular priorities and concerns based on its assessments of progress, and in response to changing circumstances and opportunities. These priorities and concerns will influence the Coordinating Board's decisions for allocating pooled partnership resources. They will also motivate the board to urge partner organizations and TB-control donors to direct energies and resources to the specified priorities and concerns.

Carefully considered and well-articulated priorities can help Stop TB partner organizations to agree upon their work plans, coordinate them, and implement them effectively. Donors need to recognize and clearly understand the Partnership's priorities if they are to increase funding for TB control. Yet as priorities become more specific, achieving consensus may become more difficult.

This suggests several principles to guide the Partnership in setting its priorities:

- The priorities should be simple and clear, and the reasons for them obvious.
- The process for analysing priorities should not be laborious or overly complex.
- The Partnership's goals in setting priorities should not be overly ambitious. Consensus priorities will be most useful if they build trust and common direction among the partners. By articulating specific priorities, the Partnership will hope to influence marginal change in the activities and resources supporting TB control, not to supersede independent decisions of partner organizations and donors.

The Coordinating Board will establish a process to identify and regularly review its priorities.

6. Monitoring the Global Plan to Stop TB

6.1 RATIONALE

A systematic approach to monitoring is essential to assess implementation of the *Global Plan to Stop TB*. The importance of accurate and systematic global monitoring has long been recognized by those working in TB control. The WHO standardized system for reporting DOTS performance, based on case detection and treatment outcome, is one of the most comprehensive and robust global disease reporting systems in the world.

Monitoring of the *Global Plan to Stop TB* is not limited to national TB-control programme performance; it will incorporate assessment of resource flows, surveillance of drug resistance, and the fulfilment of working group objectives. Many of these monitoring mechanisms are already in place and usually implemented by WHO, which has the lead role in monitoring global trends in health and disease.

The Stop TB Coordinating Board is responsible for overall monitoring of the *Global Plan to Stop TB*, and will report on progress at the Stop TB Partners' Forum.

6.2 OBJECTIVES

The primary objectives of monitoring the plan implementation are to monitor:

- progress towards fulfilling the objectives of the *Global Plan to Stop TB*;
- trends in disease burden and impact;
- TB-control programme performance; and
- activities and investments.

6.3 MECHANISMS

The following monitoring systems will be utilized by the Stop TB Partners to assess progress towards fulfilling the objectives of the *Global Plan to Stop TB*:

- annual reports on national TB-control programme performance, published by WHO, such as the Global Tuberculosis Control Report;
- surveillance of drug resistance, as part of the WHO/IUATLD global project on anti-TB drug-resistance surveillance;
- annual monitoring of TB-control investments by donors and high-burden countries, as well as of research, which will be monitored and published by WHO; and
- annual progress reports by Stop TB working groups to the Stop TB Coordinating Board.

6.4 RESOURCE NEEDS

The resources needed are currently estimated at $15 million over the coming five years. However, this estimate is not yet supported by a detailed budget.

7. Assessing Risk

Because the targets and objectives of this plan are so ambitious, there is clearly a risk that they will not be achieved. Identifying potential risks beforehand can mitigate likely effects.

7.1 DISEASE BURDEN RISKS

Failure to contain the HIV epidemic has obvious and serious consequences for containing TB. Predicting the course of the epidemic is fraught with difficulties, particularly in Eastern Europe and South Asia, where recent rapid increases in the prevalence of HIV are of great concern, and huge populations are at potential risk. If HIV-prevalence rates reach those of countries in sub-Saharan Africa, there will be an enormous increase in the TB epidemic; the capacity of public health services will be further strained; and the likelihood of reaching the global TB-control targets for 2005 and 2010 will be diminished.

Similarly, a rapid and uncontrolled increase in MDR-TB would have catastrophic consequences for TB control worldwide, substantially increasing the disease burden and resource requirements.

7.2 OPERATIONAL RISKS

Delivery of diagnostic and treatment services relies to a great extent on an effective and coordinated health service infrastructure, provided by public health services, NGOs, or the private sector. In parts of some countries, health-care services are nonexistent or poorly developed. Successful implementation of this plan will depend on the ability to scale up service provision through strengthened public health services and innovative approaches. Effective and sustainable coordination mechanisms are required to ensure continuity of standardized care for people moving between different types of service providers, and to ensure comprehensive reporting.

7.3 FUNDING RISKS

Sustainable financing of TB control is essential and will be required for many decades to come. Donor priorities have been notoriously fickle in the past, with frequent changes limiting the capacity of countries to predict resource flows over time. Equally, the capacity of some countries to disburse funds efficiently has been compromised by inadequate governance.

Potential threats to sustainable financing include changes in donor priorities and increasing economic difficulties in low-income countries. Paradoxically, success may also pose a threat, as the history of TB in several high-income countries has demonstrated that a decline in TB is frequently followed by a profound reduction in resources, leading to a recrudescence of disease—the so-called U-shaped curve of concern.