Annual Report 2006

Stop TB Partnership

Executive summary

The Global Plan to Stop TB 2006-2015 was launched at Davos, Switzerland, in January 2006. This Plan, which is underpinned by the WHO Stop TB Strategy, is a comprehensive assessment of the actions and resources needed to move forward on TB control and make an impact on the global TB burden. It calls for wider and deeper engagement of all partners.

By the end of 2006, the Stop TB Partnership comprised 517 partners, 54 more than in 2005. The Call to Stop TB was launched on World TB Day 2006 to rally established partners and others who share the concern to tackle TB in order to alleviate poverty and prevent death. It attracted nearly 700 signatories including former Secretary-General Kofi Annan, President Gloria Arroyo, Prime Minister Tony Blair, and Bishop Desmond Tutu. The former President of Portugal Jorge Sampaio took up the baton as the UN Secretary-General's Special Envoy to Stop TB and conducted many high level advocacy missions for the Partnership. The Patients' Charter for Tuberculosis Care, the first global "patient powered" standard for care developed by patients around the world, was launched in March 2006. The Kochon Prize, which marks outstanding contributions to the global fight against TB, was awarded to Mr Winstone Zulu, a leading TB/HIV activist from Zambia, and Indian TB Programme Manager Dr LS Chauhan.

The International Federation of Red Cross and Red Crescent Societies collaborated with the Stop TB partnership to provide the expertise and momentum to establish a Stop TB Partnership for Europe, to cover the WHO European Region which includes Central Asian countries.

As a result of efforts by the Advocacy, Communications and Social Mobilization (ACSM) Subgroup at country level, approximately US$ 30 million was approved in the sixth round of Global Fund grants to design, implement and monitor ACSM activities in 30 countries. This marks the highest success rate to date (62%) of proposals submitted to the Global Fund for any of the three diseases.

In 2006 the Global Drug Facility (GDF) of the Partnership approved access to 3.3 million anti-TB drug patient treatments. It approved 43 countries for new grants and placed new orders totalling US$ 29 million for recipients of its grants. GDF brokered technical assistance missions to 58 countries by drug management and TB experts. The procurement functions of the Green Light Committee (GLC) were merged with GDF. During the year GLC approved 24 applications covering more than 12,000 patients with multidrug-resistant (MDR) TB; double the number in 2005. Significant progress has been made in the development pipeline of new drugs, vaccines and diagnostics.

During 2006 intensive resource mobilization efforts following the launch of the Global Plan led to the total income of the Stop TB Partnership Secretariat rising to US$ 58 million; a 69% increase over 2005 (US$ 34.4 million). The resources entrusted to the Partnership were prudently managed, and accounting was in line with international best practice and WHO's rules and regulations.

The main constraints to full implementation of the Global Plan to Stop TB are a lack of the required political support and insufficient funds to implement the full plan. This is partly due to the lack of engagement by partners, but also due to the health workforce crisis and constraints associated with infrastructure both of health systems and outside the health sector. There is also increasing competition for resources among public health initiatives, development initiatives and other humanitarian causes. The recent emergence of extensively drug-resistant TB highlights the urgent need to speed up the development of new tools and for an increased focus on translation of the Global Plan's strategic directions into operational plans at country level. There is a need to think creatively and fully engage all Stop TB Partners to meet these challenges. This process of reflection on the role of the Stop TB Partnership is expected to be taken further with the independent external evaluation of the Partnership, commissioned by the Coordinating Board at its meeting in Jakarta, Indonesia in November 2006.

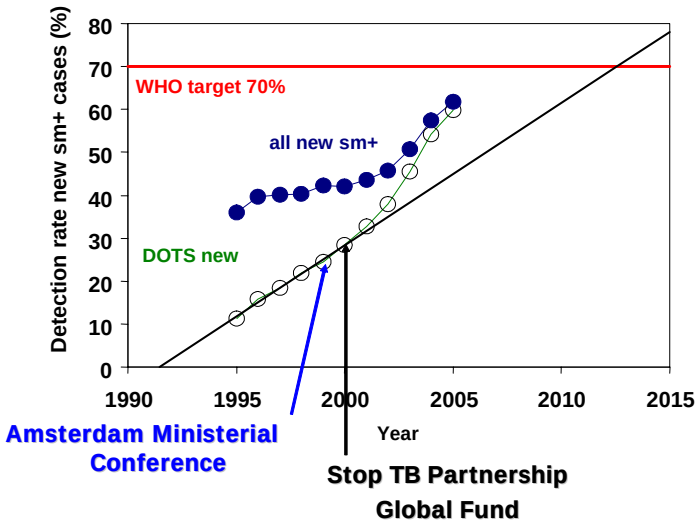
Introduction

The highlights of the year were the launch of the Global Plan to Stop TB, 2006–2015, and the appointment of the first ever UN Special Envoy for TB, Dr Jorge Sampaio, former President of Portugal. The launch took place at the World Economic Forum in Davos, Switzerland, with President Olusegun Obsanjo of Nigeria, Chancellor Gordon Brown of United Kingdom and Bill Gates, Chairman of Microsoft Corporation, and was accompanied by many satellite events throughout the world highlighting the importance of a massive global effort to control and eventually eliminate TB. The Global Plan is a comprehensive assessment of the action and resources needed to implement the Stop TB Strategy and make an impact on the global TB burden. The recent emergence of extensively drug-resistant TB (XDR-TB) highlights the urgent need to speed up the development of new tools and for an increased focus on translation of the Global Plan's strategic directions into operational plans at country level.

Using the Global Plan as a business plan, the efforts of all the partners have been directed towards delivering its various elements. The Stop TB Secretariat plays a central role as a platform for fostering collaboration and acting as a broker among partners to facilitate the design and delivery of high impact joint efforts. Case detection rates of all new TB cases, from DOTS and non DOTS programmes, remained approximately stable from 1995 to 2001 but increased between 2002 and 2005 as shown in Figure 1.

Open circles mark the number of new smear-positive cases notified under DOTS 1995–2005, expressed as a percentage of estimated new cases in each year. The solid line through these points indicates the average annual increment from 1995 to 2000 of about 134 000 new cases, compared to the average increment from 2000 to 2005 of about 260 000 cases. Closed circles show the total number of smear-positive cases notified (DOTS and non-DOTS) as a percentage of estimated cases.
The upward turn in the graph coincides with the launch of the Stop TB initiative in 1998 and the follow-up actions that culminated in the launch of the Stop TB Partnership and Global Fund in 2000/2001.

Figure 1. Progress towards the 70% case detection rate



Source: WHO Report 2007: Global Tuberculosis Control

Progress towards the 70% case detection target can be said to have been fuelled *inter alia* by the Stop TB Partnership, as confirmed by the report on the first Global Plan 1999–2003. The rapid expansion in the financial resources made available to the Stop TB Partnership over the period 2000 to 2006 is a further evidence of the value stakeholders put on the work done by the Partnership.

The activities of the Stop TB Partnership can be classified under the following main areas:

- Governance and planning
- Partner engagement
- Advocacy, communication and social mobilization
- Working Groups
- Global Drug Facility
- Resource mobilization and financial management.

Governance and planning

In 2006 governance mechanisms of the Partnership were kept well aligned and sensitive to the engagement, representation, and participation of all partners who want to be involved in the global movement, ensuring transparency and accountability in terms of the decisions taken and efficiency in disbursing our limited resources.

The Partnership Secretariat continued to act as a communicator on progress and an ambassador for Stop TB. During 2006 the Partnership Secretariat was restructured and strengthened to streamline management procedures and to support the much increased reporting requirements of donors since multiyear agreements became operationally effective.

The Stop TB Partnership Coordinating Board met twice in 2006 and there were five teleconferences of the Executive Committee. The Board held its tenth meeting in Abuja, Nigeria, on 24–25 April 2006, and discussed progress in the fight against TB in Africa; called for the development of a TB research movement; endorsed the establishment of a Task Force on Retooling; welcomed new action plans on TB & Poverty and strengthening the laboratory network; agreed to set up a business advisory group for GDF and discussed plans for the upcoming African and European Ministerial meetings. The Minister of Health of Nigeria, Dr Eyitayo Lambo, gave the opening address and the Nigerian Government provided generous support for the meeting.

At this meeting, Irene Koek, Chief of the Infectious Diseases Division, Bureau for Global Health at the United States Agency for International Development (USAID) officially became the new Chair of the Stop TB Partnership Coordinating Board. Ernest Loevinsohn of the Canadian International Development Agency (CIDA) was appointed Emeritus Chair. To reflect the importance and growing voice of TB patients and their affected communities and the interest of the Government of Italy to participate as a donor partner, additional seats were created for these constituencies on the Coordinating Board for the Abuja meeting.

In the context of the meeting a delegation of Board members visited Nigerian President Olusegun Obasanjo; a mission which helped to ensure that TB remained high on the domestic political agenda in Nigeria throughout 2006.

The Eleventh Stop TB Coordinating Board Meeting was held in Jakarta, Indonesia on 29–30 November and focused on Asia. The Board endorsed a "Call to Stop TB in Asia"; agreed a process to evaluate the added value and impact of the Partnership during 2007; discussed the emergence of XDR-TB and the implications of the upcoming study led by the World Bank on the economic implications of TB; established a process for monitoring the implementation of the Global Plan; and endorsed a guideline on New Technologies for TB Control. The Board also mandated the Secretariat to begin planning for a 2008 Partners' Forum. The Partners' Forum is the highest decision-making body of the Stop TB Partnership and critical for accountability with our stakeholders.

The Board was delighted with the support that they received from the Government of Indonesia for the meeting and that it was held in conjunction with a meeting of Partners for TB Control in South Asia. The Board was honoured that the joint opening ceremony could be addressed by Minister of Health of Indonesia, the WHO Regional Director for the South-East Asia, the WHO Assistant Director-General for HIV, TB and Malaria and the UN Secretary-General's Special Envoy to Stop TB, Dr Jorge Sampaio.

A delegation of the Partnership also had the opportunity to meet with the Vice President of Indonesia, Yusuf Kala, with whom they stressed the need for the Indonesian Government to continue prioritizing activities relating to TB control. The Vice President reassured the delegation of support to the national TB control programme at the highest level.

The inaugural Kochon Prize, established in 2006 to mark outstanding contributions to the global fight against TB, was awarded to leading TB/HIV activist Mr Winstone Zulu from Zambia, and Indian TB Programme

Manager Dr LS Chauhan. The prize, divided between the two winners, was presented by the Kochon Foundation Chairman Mr Doo-Hyun Kim and Stop TB Partnership Executive Secretary Dr Marcos Espinal at the Thirty-seventh Union World Conference on Lung Health in Paris in November 2006.

With the ambitious targets of the Global Plan to Stop TB, 2006–2015, there is a need to maximize the strategic output of the governance mechanisms that are designed to coordinate the partnership effectively and to monitor the progress made in implementing the Global Plan (Box 1). The Secretariat will aim to facilitate and administer the decisions and recommendations of the Coordinating Board. The process of planning for the next Stop TB Partnership Partners' Forum has already begun.

Box 1: Monitoring and evaluating Working Group achievements against the targets in the Global Plan to Stop TB, 2006–2015

At its meeting in November 2006, the Stop TB Coordinating Board strongly endorsed the need to establish a monitoring system for the Global Plan. A focal point has been identified for monitoring and evaluation by each Working Group, Region and by the Secretariat. A simplified and shortened standard template is under development for the collection of monitoring and evaluation parameters. From 2007, there will be annual reporting from the Working Groups, the Regions and the Secretariat against the targets and indicators in their individual strategic plans, an independent review of reports, and presentation and dissemination of the results to relevant audiences. The overall report on progress in monitoring the implementation of the overall Global Plan will be published annually. Less formal biannual updates will be made to the Coordinating Board. A small subcommittee is being created to review Working Group, Regional and Secretariat reports to ensure the implementation of a streamlined process that focuses on substantive impact indicators rather than process indicators. The first full progress report on the Global Plan to Stop TB will be published in 2008.

The main constraint to full implementation of the Global Plan to Stop TB, 2006–2015, in addition to lack of financial resources, is a lack of political engagement to honour commitments. There is a lack of "boots on the ground" to put plans into action in affected countries, partly due to a lack of engagement by partners, but also due to the health workforce crisis, i.e. the qualitative and quantitative deficiencies related to human resources capable of implementing control efforts in non-endemic countries. Constraints associated with health systems infrastructure as well as basic infrastructure outside the health sector need to be addressed concurrently with Plan implementation if access to quality TB care is to be made universal. Finally, there is increasing competition for resources among public health initiatives, among development initiatives and among humanitarian causes. There is need to think creatively and fully engage all Stop TB Partners to meet these challenges.

The WHO Stop TB Strategy (Box 2) was launched in March 2006. It has been developed within the context of an overall vision for TB control-that is, a world free of TB. It builds on the DOTS strategy and expands its scope to address the remaining challenges to TB control – an expansion that is critical to achieve the Millennium Development Goals and Stop TB Partnership targets.

BOX 2: Stop TB Strategy objectives

- To achieve universal access to high quality diagnosis and treatment for people with TB.
- To reduce the suffering and socio economic burden associated with TB.
- To protect poor and vulnerable populations from TB, TB/HIV and MDR TB.
- To support the development of new tools and enable their timely and effective use.

Partner engagement

Strengthening the coalition of partners

The network of partners was consolidated further during 2006 with the following:

- At the end of 2006, the Stop TB Partnership was composed of 517 partners, 54 more than at the end of 2005. The geographic spread and nature of these partner organizations is shown in Tables 1 and 2 and Figure 2, and their activities are profiled in the Partners Directory, available through the Stop TB web site (www.stoptb.org).

- In 2006, 12 partners were profiled on the Stop TB web site: the Damien Foundation, the International Union Against Tuberculosis and Lung Disease, the Tuberculosis Survival Project, The Norwegian Association of Heart and Lung Patients, TB Alert, TB Care Association, the Afro Global Alliance, The International Pharmaceutical Students' Federation, ASET Comas, Agence de Coordination en Etudes Internationales de Santé, Icons of Europe, and Destination Santé.

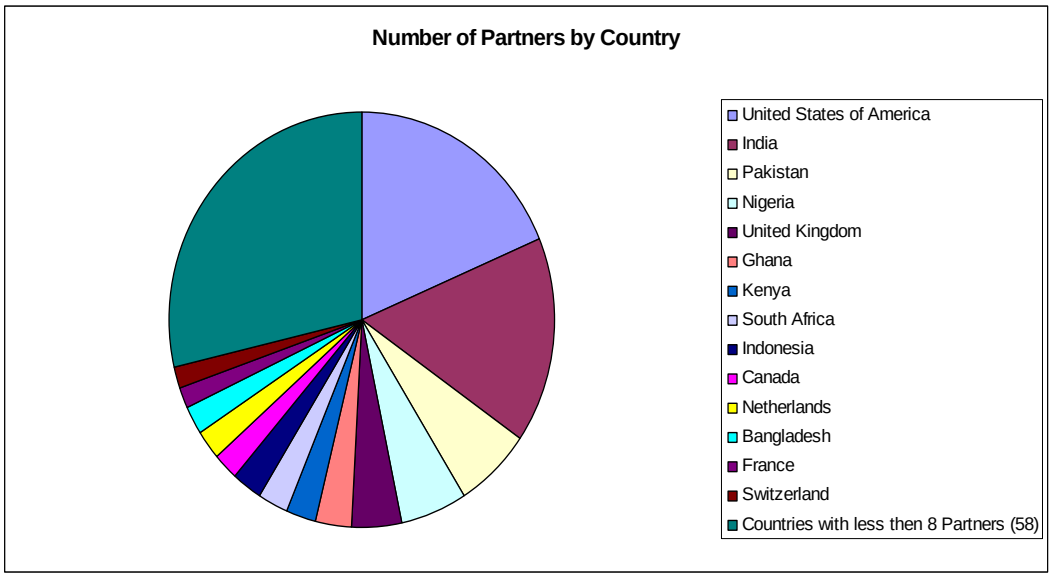
Table 1
Classification of partners of the Stop TB partnership by organization type

Organization type	*Number of partners*
	2006
Academic institution	46
Donor organizations	10
For-profit corporation	34
Governmental organizations –technical	35
Intergovernmental organization	14
Nongovernmental organization – foundation	54
Nongovernmental organization – general	231
Nongovernmental organization – network	54
Other	39
Total	**517**

Table 2
Classification of Stop TB partners by country

Country	*Number of partners*
	2006
Bangladesh	11
Canada	12
France	9
Ghana	15
India	84
Indonesia	12
Kenya	14
Netherlands	12
Nigeria	29
Pakistan	32
South Africa	13
Switzerland	8
United Kingdom	22
United States of America	96
Others (countries with < 8 partners)	148
Total	**517**

Figure 2



Enhancing outreach to partners

Two specific initiatives were launched in 2006 to increase the outreach to Partners:

- The Call to Stop TB launched on World TB day 2006 is a strategy to rally both established TB partners and others who share our concern that TB can and must be addressed to prevent needless deaths and alleviate poverty. The Call to Stop TB had attracted nearly 700 signatories by the end of 2006, including former Secretary General Kofi Annan, President Gloria Arroyo, Prime Minister Tony Blair, and Bishop Desmond Tutu. This initiative will be developed into a full campaign in 2007.

- The Patients' Charter for Tuberculosis Care (the Charter) was initiated and developed by patients around the world and launched in March 2006. It sets out the ways in which patients, the community, health providers (both private and public), and governments can work as partners in a positive and open relationship to improve TB care. The Charter is underpinned by the principles on health and human rights of the United Nations. It outlines the rights and responsibilities of people with TB and empowers them and their communities through this knowledge. This is the first global "patient powered" standard for care, forged from common cause. The Charter was developed in tandem with the International Standards for Tuberculosis Care (see page) to promote a "patient-centred" approach.

Supporting national and regional partnerships to achieve their objectives

Spurred on by the declaration of a TB emergency in the European Region, the poor uptake of DOTS and the increasing threat posed by MDR-TB, the Stop TB Partnership for Europe was launched in October 2006 at a meeting of 25 leading European organizations hosted by the International Federation of Red Cross and Crescent Societies in Geneva, Switzerland. Its achievements are shown in Box 3.

Box 3: Confronting the TB emergency in Europe

The International Federation of Red Cross & Red Crescent Societies played a key role in providing the expertise and momentum to establish a Stop TB Partnership for Europe, to cover the WHO European Region which includes Central Asian countries. Such a partnership was considered to be critical to confronting TB and, in particular, MDR-TB which threatens Europe. In the first six months of the partnership the following achievements have been recorded:

- Successful outreach to 30 leading European health, donor and advocacy organizations to join the new partnership.
- Agreement on main goals, structure, and an initial 10 point Action Plan.
- Generation of high-level media coverage of the partnership launch across Europe and globally
- Meetings with senior-level EC officials and permanent missions in line to assume the EU presidency (Germany, Portugal and Slovenia).
- Formation of an influential "Brussels group" to lead advocacy efforts vis-à-vis the European Commission and Parliament.
- Mobilization of the Federation Secretariat and selected Red Cross societies in EU countries (France Germany, Sweden, United Kingdom) to support Partnership activities.
- Inclusion of financial support for activities of the Coordinating Office in the annual appeal of the Federation for 2007.
- Planning for two major public events for World TB Day 2007: a scientific symposium in the European Parliament in Brussels (funded entirely by ECDC) and an international symposium in Berlin (funded by the global Partnership and local sponsors), with active support from the Red Cross-EU office and German Red Cross respectively.

Partnership development

Steps were taken to launch new partnerships and to assess the contributions made by existing ones through the following key events.

- Setting up a task force for building national partnerships under the umbrella of the Advocacy, Communication and Social Mobilization Working Group.

- A national partnership in Ghana was launched in 2006 to join those in Brazil, Canada, Indonesia, Islamic Republic of Iran, Italy, Mexico, Pakistan, Peru, Sudan, Uganda, and USA. National partnerships to Stop TB bring all national stakeholders together to raise awareness for greater engagement and commitment

- Commissioning of an independent external evaluation of the Global Partnership by the Coordinating Board at its meeting in Jakarta in November 2006.

- In November 2006, the Stop TB Coordinating Board endorsed a plan to hold a Partners' Forum in 2008 to report on implementation of the Global Plan to Stop TB, to engage and mobilize partners and strengthen political commitment to the Plan, and to bring Ministers together for a summit to discuss progress on funding the Plan at national level.

- The first-ever Indonesian National TB Congress took place in Jakarta, Indonesia, in November 2006, with participation of over 1000 health professionals, politicians, health-care providers, NGO activists, and TB staff from throughout the country. The Congress was opened with a strong statement of continued political commitment from both the Minister of Health and the Minister of Welfare. The National TB Partnership movement 'Gerdunas' reviewed its organization and membership, and carved out new mechanisms for best supporting the 5-year national TB plan 2006–2010.

The success of the Stop TB partnership depends on the work of all of its partners. This section highlights the profiles of some partners and projects led by them.

The Norwegian Association of Heart and Lung Patients
The Norwegian Association of Heart and Lung Patients (LHL), Norway's largest patients' organization, emphasizes the role of self-help and peer support in overcoming heart and lung diseases. LHL carries out socio-political and lobbying work as well as supporting TB programmes and projects in seven countries The Association's goal is to help persons suffering from illness or disability to participate in society on an equal basis.

Afro Global Alliance
The Afro Global Alliance (AGA), founded in 2003, is a non-profit NGO with headquarters in Nigeria and offices in Ghana and with a growing number of affiliates around the world. One of its aims is fight against infectious diseases such as TB, HIV and malaria through education. AGA's strategy is to make an impact through joining and initiating partnerships and it has programmes in TB control, advocacy and implementation. Volunteers in the health sector are closing the communication gap between rural and urban populations by reaching communities in the languages they understand. AGA believes that "if an individual is affected, the community is affected".

Agence de Coordination en Etudes Internationales de Santé (ACOETIS)
With the backing of international organizations and civil society, ACOETIS provides multidisciplinary expertise in the coordination of national and international health programmes, and promotes sustainable development in developing countries through skills transfer. The mission of ACOETIS is that equitable access to quality care should be a reality for people living with TB and AIDS. This international not-for-profit organization is currently present in six developing countries.

The Tuberculosis Survival Project
The Tuberculosis Survival Project, a web-based project, funded by people who have had TB and Ely Lilly, launched on World TB Day 2006, is a patient-led initiative that aims on the one hand to inform and raise awareness of TB, and on the other, to provide peer support to those being treated for MDR-TB. The project offers current TB news, a news archive and a place on the web site where people can write about their own experience with TB and MDR-TB. The Tuberculosis Survival Project aims at "helping people with TB/MDR-TB to help themselves". The site is supported by an unrestricted educational grant from Eli Lilly and Company.

Advocacy, communication, and social mobilization

Placing TB on the global development agenda

The most compelling advocacy event of 2006 was the launch of the *Global Plan to Stop TB, 2006–2015*, at the World Economic Forum at in Davos, Switzerland, and at a series of events in London, Moscow, Nairobi, Ottawa, Paris, and Washington, DC.
Several prominent persons gave their support to considerably raise the profile of TB. Notable among these were: Dr Jorge Sampaio, former President of Portugal (Box 5), the former President of Zambia Kenneth Kaunda, and Mr Michael Barnier, former French Minister of External Affairs. Several national Stop TB Partnerships have appointed their own high profile Stop TB champions. In 2007 this area will be developed through the Call to Stop TB campaign.

Box 5: UN Special Envoy lends his active support to the Stop TB Partnership

Former President of Portugal Dr Jorge Sampaio, took up the challenge to become the UN Secretary General's Special Envoy to Stop TB. He has said that "the success of the Partnership's Global Plan to Stop TB (2006-2015) requires on the one hand,
mobilization of the necessary resources and on the other, strong political commitment from all countries to fully implement the actions set out in the Global Plan". Therefore he defined his main principles for action during this first period as threefold:

1. Urging world leaders to follow through on political commitments;
2. assessing the current status of TB control and identifying achievements, shortfalls, expectations and results;
3. determining how to mobilize additional resources in order to fill the funding gap for TB control.

To deliver on these principles, President Sampaio embarked on a busy schedule of meetings and events, summarized below.

June 2006 – Attendance at the UN General Assembly on HIV/AIDS (UNGASS); meeting the UN Secretary-General; writing to all the G8 leaders encouraging them to prioritize TB for discussions at the St. Petersburg Summit; and preparing a message for the Summit of Portuguese-speaking countries held Guinea-Bissau in July 2006.

August 2006 – At the Fifty-sixth Regional Committee for Africa held in Addis Ababa, Ethiopia, Dr Sampaio urged Health Ministers to develop national plans to combat the TB epidemic. He also had a bilateral meeting with African Union President Alpha Konaré.

September 2006 – Attendance at the Clinton Foundation Summit where he met several world leaders.

October 2006 – Key events were:

- Meeting with José Manuel Barroso, President of the European Commission;
- Delivering the opening address at the European CEO Summit on Business and AIDS. This summit was an opportunity to encourage improved TB/HIV collaborative activities and outline opportunities for private sector involvement in the fight against TB.
- meeting with Enrique Iglesias, Secretary General of the Ibero-American Community. The Ibero-American Heads of States Summit to be held in Uruguay in November 2006 adopted a statement on TB.

November 2006 – Delivering the opening address at the inaugural session of the Thirty-seventh Union World Conference on Lung Health in Paris, France, and participated in the Stop TB Partnership Coordinating Board meeting in Jakarta, Indonesia, and also met with the Vice President of Indonesia.

Dr Sampaio has sponsored and actively collaborated in a special TB edition of *Correio da Manhã*, the largest daily Portuguese newspaper.

The Chairs of all the Working Groups and representatives of the TB affected community met in Paris to facilitate engagement between the two constituencies to support country planning and implementation of the Stop TB Strategy. This meeting was opened by the Executive Secretary of the Stop TB Partnership and a report of its proceedings was prepared by the Treatment Action Group. It concluded that the overarching challenges in this area were:

- Alignment of national plans with the Global Plan.
- Political commitment with sustained and /or increased resources to reach MDGs.
- Health system strengthening.
- Better coordination of the efforts of multiple partners.

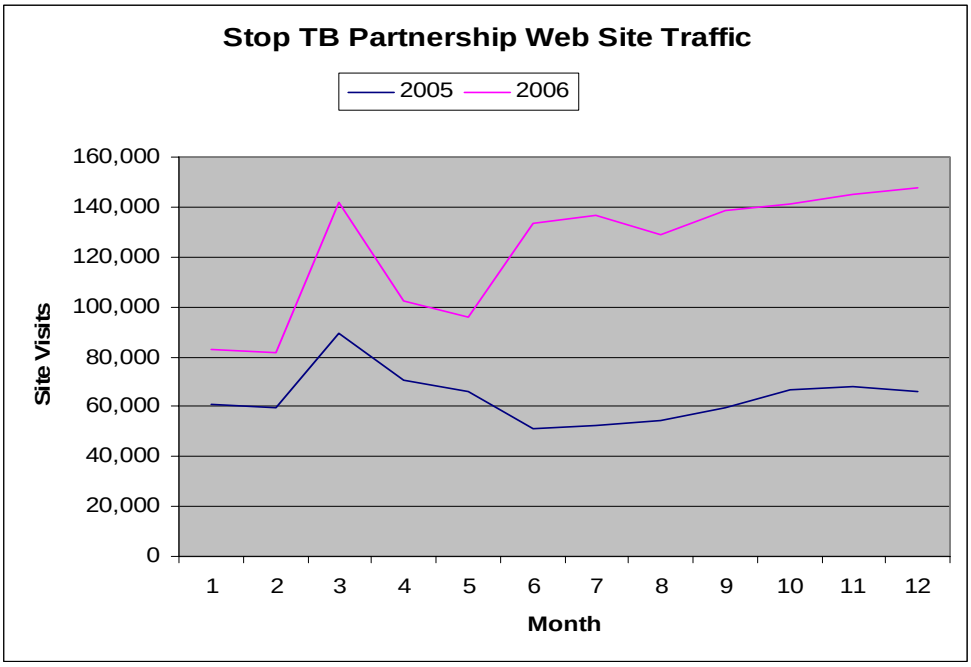
Keeping partners and the world informed

The Stop TB web site was enhanced considerably to improve access to information and News on TB.
High quality information tools are essential for effective advocacy and communication and the web site is a critical entry point. The Stop TB Partnership web site attracted 1.5 million visits in 2006 (figure 3), an increase of 93% over the previous year and the *Global Plan to Stop TB, 2006–2015* was downloaded over 150 000 times from the site. The web site evolved in 2006 in its architecture, design, navigation and usability. Several sub-sites were added including the Global Plan to Stop TB, 2006–2015, the Call to Stop TB, World TB Day 2006, and

the Advocacy, Communication and Social Mobilization Global Advocacy for Resource Mobilization Sub-Group.

The Stop TB Partnership Secretariat will continue to streamline and standardize its operating procedures to aid the mobilization of sufficient resources to enable the implementation of the Global Plan to Stop TB, and achieve the mission and goals of the Partnership.

Figure 3



Retooling – preparing for the introduction of new tools to combat TB

An innovative pipeline of new drugs and vaccines is being developed through the New Tools Working Groups. Adoption and timely introduction of these tools, as they become available, will require coordinated action by members of the Stop TB Partnership. At the Coordinating Board meeting in Abuja, a task force on retooling was established and mandated with the development a strategy on implementing new tools in the field (see Box 6).

Box 6: The Retooling Task Force

Past experience in other disease areas has shown that there is often a significant delay between availability of new tools at the global level and their eventual implementation at country level for disease control and prevention. Recognizing this time lag, the Stop TB Partnership Coordinating Board established the Task Force on Retooling in May 2006. One of its first goals was to develop a framework for the adoption, introduction and implementation of new tools. The final draft document was submitted to the Coordinating Board for endorsement in November 2006.

The document provides an overview of technical and operational considerations for retooling at global and national levels, identifies challenges, and proposes key steps for facilitating appropriate and timely implementation. The annexes summarize the technologies in the development pipeline. They provide an illustrative list of key actions for their adoption and implementation of the new TB tools in each technology category and a generic timeline, or sequence of key tasks, for adoption, introduction and implementation. A list of suggested further reading is also provided.

The Retooling Task Force has also developed its work plan for the year 2007 which includes the development of a stakeholder engagement plan; detailed illustrative timelines for adoption and implementation of new diagnostics; monitoring and evaluation indicators; and pipeline updates for drugs, diagnostics and vaccines.

The Advocacy, Communication and Social Mobilization Working Group

In July 2006, Paul Sommerfeld from TB Alert, an NGO in the United Kingdom, was elected as Chair. The Working Group was restructured so as to align its objectives with those in the *Global Plan to Stop TB, 2006–2015*, the new WHO *Stop TB Strategy*, and the aims of the other working groups of the Stop TB Partnership. Subgroups were formed on Global Advocacy for Resource Mobilization and ACSM at Country Level.

Task Forces

The Global Advocacy subgroup established three task forces to:

- improve media, events, and information products
- engage businesses
- establish liaison points with the existing G8 and EU Task Forces.

and three cross-cutting task forces to:

- build national partnerships
- improve patient-led national advocacy
- improve communication and social mobilization for XDR-TB.

The following were the key activities of the Task Forces in 2006:

- The Media and Events Task Force
  - developed a Common Messaging Platform to ensure resonance and consistency of messaging among partners and across several key conferences and events.
  - helped to generate extensive coverage of XDR-TB and the need for new tools at the Union conference in Paris in October/November 2006
  - developed the campaign theme for World TB Day 2007: 'TB Anywhere is TB Everywhere'
  - supported the Panos Institute in training 20 journalists from 10 countries around the world on TB issues.
- The **Building National Partnerships Task Force** drafted guidelines to help nascent national Stop TB Partnerships to get started and held a workshop on the new guidelines in November 2006.
- The **G8 Task Force** drafted a consensus Stop TB Partnership statement for inclusion in the Saint Petersburg G8 Communiqué and ensured its inclusion in the final document through high level advocacy.

Global advocacy for resource mobilization

In collaboration with the Stop TB Secretariat, the subgroup raised resources in the period in 2006 to implement global advocacy activities, implement the Call to Stop TB, and increase media visibility of TB. The main achievements of the sub-group were:

- Dr Kenneth Kaunda representing the Stop TB Partnership at the Special Summit of the African Union on HIV/AIDS, Tuberculosis and Malaria in May 2006. The summit resulted in the call for accelerated action towards universal access to AIDS, tuberculosis and malaria services in Africa, and a resolution to achieve this by 2010. This call was presented to the World Health Assembly by the African Union in May 2006.
- The United Kingdom Government responding to cross-party concern for the growing scale and impact of the TB epidemic, and demonstrated its commitment to halting and reversing the incidence of TB worldwide, by establishing an All Party Parliamentary Group on Global Tuberculosis (APPG). The APPG will act as a forum for discussion and a platform for further strategic action to raise the profile of TB in the British parliament. Members of the ACSM Working Group and of RESULTS UK form the secretariat of APPG.
- Identifying eight countries, sectors, and institutions as a first priority for accelerated advocacy activities in 2007–2008. They include: four oil-rich countries, and Italy Japan, Norway, and Spain;

investment pools including the private sector, regional development banks; and Rotary International. This list will be amended in the light of results obtained.

World TB Day

A number of events structured around the theme of the day, *Actions for life: towards a world free of Tuberculosis,* were held to highlight the importance of implementing the Global Plan to Stop TB. The main highlights include:

- Local events in countries calling for stronger support to TB control and Global Plan with the participation of Stop TB Partnership representatives including its Secretariat and Partners.
- WHO launched the Global TB Control Report for which the Partnership provided strong support.
- World wide launch of International Standards for Tuberculosis care, Diagnosis, Treatment, Public health.
- Broadcasting of special 12-15 minute radio programmes in the European region on how to prevent TB and in the sub-Saharan Africa and Arab middle-Eastern region on the general overview of the situation in the region with interviews on current TB status in the region and how to better implement prevention, diagnosis and treatment.
- A Stop TB exhibition was held at WHO HQ in Geneva. This consisted of information on the Global Plan to stop TB, The Global TB control report, general information material on TB and screening of films and videos.

ACSM at Country Level: translating country-level resources into action and results

The main achievements of the Country level ACSM subgroup were:

- approval of approximately US$ 30 million in the sixth round of Global Fund grants to design, implement and monitor ACSM activities in 30 countries;

- securing of funding for a new technical assistance mechanism from PEPFAR through USAID to improve absorptive capacity and for enhancing performance of the ACSM component of the grants. As part of the ACSM subgroup the TB Technical Assistance Mechanism (TB TEAM) will coordinate technical assistance to all Global Fund countries with ACSM activities, upon their request. The goal is to expand the number of countries (currently 19) that have multisectoral, participatory ACSM initiatives.

At the subgroup meeting in Milan, Italy, a significant increase in ACSM funding via the Global Fund grant process was noted; however ASCM resource utilization by National TB Programmes needs to be accelerated and effectively monitored.

The DOTS Expansion Working Group

A two-day event was held in connection to the Thirty-seventh Union World Lung Conference in Paris, France, on the theme "From DOTS to the Stop TB Strategy: Building on Achievements for Future Planning". The first day brought together representatives from the 22 high-burden countries (HBCs) and Core Groups of the DOTS Expansion, TB/HIV and MDR-TB Working Groups; the second day was devoted to a symposium open to the TB community. The purpose of the two-day event was to discuss major challenges and possible solutions to scaling-up TB control in line with the new *Stop TB Strategy* and the *Global Plan to Stop TB, 2006–2015*, in the 22 high TB burden countries. It was also an opportunity to update the TB community on the recent progress made in TB control at country level and by all seven Working Groups of the Stop TB Partnership.

DOTS expansion in countries

All WHO regions have initiated (and three have finalized) the development of regional medium-term plans (with inputs from all DEWG partners) in line with the Stop TB strategy. The TB TEAM provided technical assistance and support to the development of country strategic plans to ensure their compatibility with the Global Plan to Stop TB 2006-2015. The implementation of these plans is being monitored on an ongoing basis through in-country reviews and monitoring missions.

Supporting countries in resource mobilization for ACSM activities

The TB TEAM, in coordination with the Secretariat of the Global Fund, held a TB proposal preparation workshop in Geneva, Switzerland, for the sixth round of funding, using the Stop TB Strategy Planning Frameworks. The TB TEAM also supported 48 countries in the proposal development process for the sixth round. These efforts yielded the highest success rate for TB proposals (62% success and 71% of those supported by the TB TEAM). This represents the highest success rate for any disease for all Global Fund rounds.

Laboratory strengthening

The strategic approach for strengthening TB laboratories was launched in 2006 with the objective to improve the access to quality-assured sputum smear microscopy, and to expand culture and antimicrobial susceptibility testing, in line with the Stop TB Strategy and Global Plan. This strategic approach has been disseminated to all regional offices as well as at various meetings, and is currently being implemented in high burden countries (HBCs).

Despite national and international efforts at global level, in June 2006, a laboratory survey carried out in 75 countries, among them 15 high burden countries; showed that laboratory services were still sub-optimal due to insufficient infrastructure, funding, equipment and supplies, human resources and implementation of quality assurance. A number of training packages and courses were developed to tackle some of the gaps in laboratory services. For example,

- a smear microscopy training package developed by CDC, WHO and partners
- a course on culture and antimicrobial susceptibility testing, to be field tested in 2007
- training material on external quality assurance for sputum microscopy
- a laboratory management course for the heads of the national reference laboratories

With the aim to increasing the number of laboratory consultants, training materials the first laboratory consultant training course took place in July 2006. During 2006 the Subgroup of Laboratory Capacity Strengthening (SLCS) decided to establish a core group in order to set strategic directions and facilitate decision-making. Technical assistance was provided to priority countries and assessment missions to 31 countries were organized in 2006. Recommendations on performance improvement were agreed upon and members of the SLCS are currently following up on the implementation.

Engaging all health-care providers – Public–Private mix (PPM) approaches

The "*International Standards for Tuberculosis Care (ISTC)*" document aimed primarily at engaging private health-care providers in TB control was launched simultaneously in several countries. Ten HBCs have developed plans to use ISTC as an advocacy and training tool for PPM approaches.

The PPM Subgroup published: "*Engaging all health care providers in TB control – guidance on implementing public-private mix approaches*". With assistance from the Subgroup, countries have made significant progress in implementing PPM for TB control; all 22 HBCs now have some PPM activity in place and 11 have started to scale up. The Subgroup held its fourth meeting in Nairobi, Kenya, with a special focus on PPM in Africa, and

highlighted the relevance of PPM in engaging diverse care providers not only in TB control but also in TB/HIV collaborative activities and management of MDR-TB.

In 2006 a framework for incorporating PPM into Global Fund applications was developed, an advocacy brochure was produced, and PPM was incorporated into the revised recording and reporting system for TB. A comprehensive PPM training package was prepared and the first PPM consultant training workshop was organized in Geneva, Switzerland. PPM has also been integrated into the TB consultant training courses offered in Sondalo, Italy, and by the Japan Anti-TB Association (JATA).

Prioritizing the needs of the poor and vulnerable

The Subgroup on TB & Poverty finalized an Action Plan on TB & Poverty which was approved by the Stop TB Coordinating Board at its meeting in Abuja, Nigeria. In 2006 a course on TB and Poverty was organized by KNCV at the Union conference. The Subgroup has also entered into discussions with the New Diagnostics Working Group about the importance to the poor of access to one-stop diagnosis.

The Childhood TB Subgroup met with the joint DEWG, TB/HIV and DOTS-plus Working Groups and agreed on the need to promote implementation of the guidance for national TB programmes on managing childhood TB. This guidance includes the new policies on recording and reporting by age-groups; the recommended dose of Ethambutol for children; mainstreaming research priorities as part of routine programme activities; and promoting child-friendly formulations of anti-TB drugs.

Working Group on MDR-TB

The occurrence of extensively drug-resistant TB (XDR-TB) highlights the urgent need to focus on translating the Global Plan's strategic directions into effective operations at country level and to accelerate the development of new tools. In 2006 the management of MDR-TB (and XDR-TB) was confirmed as a critical component of TB control as set out in both the *Global Plan to Stop TB, 2006–2015*, and WHO's new *Stop TB Strategy*.

The magnitude of the MDR-TB problem

Extensively drug resistant TB (XDR-TB)

The first global compilation of XDR-TB data by the US Centres for Disease Control and Prevention (CDC), WHO and 25 supranational TB reference laboratories (SRL) indicated that resistance to second-line anti-TB drugs was present worldwide. In response to this international concern and the high mortality rates observed in an HIV-associated outbreak of XDR-TB in Tugela Ferry, KwaZulu-Natal Province, South Africa, an expert consultation was organized jointly by MRC, WHO and CDC in Johannesburg, South Africa.

A WHO Global XDR-TB Task Force meeting in October 2006 produced recommendations on key responses, beginning with strengthening of basic TB control and proper management of MDR-TB following WHO guidelines.

Several meetings were organized with South African Development Community (SADC) countries to better understand the magnitude and spread of XDR-TB and ensure that properly coordinated prevention and control activities were in place. SADC countries agreed to develop MDR-TB and XDR-TB response plans, to carry out rapid XDR-TB surveys among known and suspected MDR-TB cases, and to consider future management of MDR-TB in collaboration with the Green Light Committee (GLC). Significant technical and financial assistance was provided to these efforts by WHO, CDC, PIH and KNCV, supported by several donors including the UK Department for International Development, Italian Cooperation, Open Society Institute and US Agency for International Development (USAID) who together provided about US$ 8 million for the XDR-TB response.

A web site on XDR-TB was set up and an MDR-TB and XDR-TB Response Plan for 2007 developed (to be finalized early in 2007) with the aim to mainstream XDR-TB response activities into day-to-day TB control activities.

Regular drug resistance surveillance

In 2006, drug resistance surveillance coverage expanded by 10%, including impressive scale-up in China and India. Other countries that completed, have ongoing or are planning drug resistance surveys in the near future include Armenia, Azerbaijan, Botswana, Democratic Republic of the Congo, Ethiopia, Georgia, Kyrgyzstan, Lesotho, Madagascar, Malawi, Mozambique, Namibia, Republic of Moldova, Rwanda, Senegal, Uganda, United Republic of Tanzania, Uzbekistan and Zimbabwe. Routine drug resistance surveys will now incorporate tests of susceptibility to second-line anti-TB drugs on all MDR-TB isolates collected. These tests will be conducted at the SRL and their results will be instrumental in providing global data. Countries are recommended to include larger sample sizes for re-treatment cases, and incorporate HIV testing where possible.

Quality-assured laboratory testing

The Supranational TB Reference laboratory network added a laboratory in the South-East Asia Region that will assist at least four countries over the coming years. Funds have been raised to expand the network with at least one additional laboratory for the African Region. The annual meeting of the network was held in Paris in November 2006.

The Russian Federation has implemented a laboratory quality assurance system in over 30 regions.

Management of MDR-TB patients

The new WHO guidelines for the programmatic management of drug-resistant tuberculosis were launched in May 2006.To improve the understanding of MDR-TB surveillance and control at country level, MDR-TB management workshops took place in four WHO Regions and more than 100 key staff of national TB control programmes were trained. In addition, 25 additional MDR-TB consultants received training at the WHO Collaborating Centre for Research and Training in Management of MDR-TB, in Riga, Latvia. The participants will be further exposed to the issues of MDR-TB control at country level by joining GLC missions in 2007.

At the fifth annual meeting of the Working Group the major bottlenecks to the global scale up of MDR-TB management were discussed and an outline operational plan was drafted in line with the Global Plan to Stop TB, 2006-2015. Three new subgroups, on research, advocacy and resource mobilization, and second-line drug management and procurement, were launched.

At a two-day event in October in Paris, France, on the theme "From DOTS to the Stop TB Strategy: Building on Achievements for Future Planning" the MDR-TB Core Group agreed to accelerate efforts to tackle the constraints in scaling-up MDR-TB management. The Group was also expanded to allow more country participation.

Availability of second-line drugs

By the end of 2006, 13 second-line anti-TB drug product dossiers had been submitted to WHO for prequalification but none was successful due to continued failure of manufacturers to comply with the prequalification requirements. Recognizing the importance of capacity building through training and hands-on practice, workshops were organized in China and the Russian Federation to assist local manufacturers to submit appropriate dossiers to the WHO prequalification project.

The International Dispensary Association (IDA) was re-selected through a competitive tender process for the supply of second-line anti-TB drugs to GLC-approved projects until the end of 2008.

UNITAID agreed to support the WHO prequalification project for HIV, TB and malaria drugs.

The Green Light Committee (GLC)

By December 2006, the GLC had cumulatively approved 53 projects covering more than 25 000 MDR-TB patients in 42 countries. During the year it approved 24 applications covering more than 12, 000 patients with MDR-TB; double the number in 2005. However, despite this encouraging trend in countries applying to the GLC, currently less than 5% of patients with drug-resistant TB are covered worldwide, highlighting the need for countries to make increased and urgent use of the GLC services.

Table 3
Countries supported by GLC in the treatment of MDR-TB patients

Projects were approved in 2006 from:	Projects approved prior to 2006 from:			Applications under review from:
Armenia	Azerbaijan	Jordan	Peru	China
Bangladesh	Bolivia	Kenya	Philippines	India
Belize	Costa Rica	Kyrgyzstan	Romania	Lesotho
Burkina Faso	Dominican Republic	Latvia	Republic of Moldova	Russian Federation
Cambodia	El Salvador	Lebanon	Russian Federation (12 oblasts)	Uganda
Democratic Republic of the Congo	Egypt	Lithuania	Syrian Arab Republic	Ukraine
Ecuador	Estonia	Malawi	Timor-Leste	
Guinea	Georgia	Mexico	Tunisia	
Kazakhstan	Haiti	Mongolia	Uzbekistan	
Paraguay	Honduras	Nepal		
Rwanda	India	Nicaragua		

In 2006 the GLC reshaped, streamlined and strengthened its processes to respond to increasing demands from countries and to provide for the targets outlined in the Global Plan to Stop TB and the Stop TB strategy. New instructions for applications to the GLC and the new guidelines for the Programmatic Management of Drug-Resistant Tuberculosis, launched in 2006, provide a completely new foundation for scaling-up programmes for the sound management of drug-resistant tuberculosis worldwide.

GLC membership was extended to three more representatives: KNCV Tuberculosis Foundation, Hospital Muniz (Argentina) and World Care Council (representing the TB community).

As a step towards meeting the global need for expansion of management of drug-resistant TB, the GLC has built and continues to strengthen partnerships with major funding mechanisms such as the Global Fund and UNITAID. At the Thirteenth Global Fund board meeting it was decided that countries requesting funds for MDR-TB control must include a cost-sharing element for GLC services corresponding to a flat rate per grant per year not exceeding US$ 50 000. US$ 2 million was made available by USAID to support costs associated with providing technical assistance and monitoring for Global Fund grant recipients with an MDR-TB objective.

UNITAID, a new innovative financing mechanism for TB, HIV and malaria drugs led by Brazil, Chile, France, Norway and the United Kingdom, agreed to provide US$ 20 million for second-line anti-TB drugs to GLC-approved projects mainly in low-income countries.

For the third year, Eli Lilly provided funds to WHO (US$ 678 000) for technical assistance to GLC-approved countries and training activities focused on Africa, South-East Asia, China, India and the Russian Federation. The Bill & Melinda Gates Foundation provided US$ 850 000 for the sustainability of the GLC.

The TB/HIV Working Group

Expanding collaborative TB/HIV activities

During 2006 the group continued to monitor and promote country-level implementation of collaborative TB/HIV activities and to develop a sound evidence base and policies to provide high-quality care for HIV-infected TB patients.

The list of TB/HIV priority countries was updated. It currently includes 63 countries; i.e. all countries with an adult HIV prevalence ≥ 1%, and five additional countries (Brazil, China, India, Indonesia and Viet Nam), which together make up 98% of the global burden of HIV-infected TB patients.

Fifty-eight of the 63 priority countries provided data for the WHO Annual Global TB Control Report. Of these 58, 50–60% had:

- appointed a TB/HIV focal point in the NTP,
- developed a formal procedure and a national plan for implementing TB/HIV activities,
- a policy of testing TB patients for HIV and for providing HIV care and treatment to those with TB, and
- a policy to provide CPT and ART to HIV-positive TB patients.

To improve recording and reporting of the implementation of collaborative TB/HIV activities, the Working Group in coordination with other Working Groups and partners revised TB recording and reporting formats to give due emphasis to HIV-related inputs.

Diagnosis and treatment of TB in HIV-positive patients

Guidelines to expedite the diagnosis and treatment of TB in HIV-prevalent and resource-constrained settings were updated by revising previously-used case definitions and diagnostic algorithms. These recommendations are aimed at both TB and HIV control programmes and imply different approaches to management of TB in HIV-prevalent and non-prevalent settings.

The TB component of the WHO Guidelines on ART was updated with new recommendations for the use of Nevirapine and the definition of Immune Reconstitution Syndrome (IRIS).

The Working Group was actively involved (with other working groups, see page 7) in the response to the emergence of XDR-TB. As a result, following a decision by the Stop TB Partnership Coordinating Board, it has established a subgroup on infection control.

A TB/HIV addendum for inclusion in the WHO Guidelines for the Prevention of Tuberculosis in Health Care Facilities in Resource-Limited Settings was drafted by CDC, USAID, US PEPFAR, The Union and WHO.

Through partnering with the International AIDS Society, WHO, UNAIDS, Treatment Action Group and Forum for Collaborative HIV Research, the Working Group ensured a high visibility for TB/HIV during the XVI International AIDS Conference in 2006 in Toronto, Canada. TB/HIV was addressed in various sessions throughout the conference and a special Working Group meeting highlighted the need for TB prevention, diagnosis and treatment to be core functions of HIV prevention, treatment and care services. The Working Group improved its communication with publication of a regular newsletter, scientific publications in peer-reviewed scientific journals, and an updated web site.

Working Group on New TB Diagnostics

Developing and evaluating a portfolio of new diagnostic tools

Significant progress has been made in advancing promising new products along the development pipeline including a new phage-based test for the detection of rifampicin-resistant *M. tuberculosis*, and simplified nucleic acid amplification tests.

The literature describing evaluations of commercially-available serological antibody detection tests in the diagnosis of pulmonary and extra-pulmonary TB was reviewed. The findings indicate that the serological tests evaluated perform poorly and have little or no place in the diagnosis of tuberculosis.

MGIT demonstration projects supported by FIND have been undertaken in some countries. Results of these projects are expected to be available early 2008.

At the Working Group meeting during the IUATLD World Conference in November 2006, updates on the development of LED-based fluorescence microscopy systems and LAMP technology for TB diagnosis were presented. Progress to date in developing a breath test for TB, and in a major TB antigen discovery programme, was also reviewed.

Improving existing tools

A series of studies of sputum smear microscopy were undertaken to provide insights into how this diagnostic tool may be optimized, and to define standards against which to judge new technologies. On the basis of the results, large multicentric studies were planned and diagnostic trial sites selected to determine:

- the optimum timing and composition of sputum specimen sets for efficient diagnosis of sputum smear positive patients;
- the value of low-cost fluorescence microscopy systems for the diagnosis of sputum smear positive patients;
- the value of sputum processing methods, such as bleach digestion, in improving sputum smear microscopy.

Implementing new diagnostic tools

GDF proposes to include TB diagnostics in its programme, in order to provide a mechanism for expanding access to, and availability of, high-quality diagnostics in support of global DOTS expansion. The UNITAID board also agreed to consider supporting MDR-TB diagnostics.

Working Group on TB Drug Development

The drug development pipeline

In 2006 the Working Group initiated an activity-mapping exercise to track additions and updates to the global pipeline of TB drugs. A web-based survey was developed to allow for data collection on a continuing basis and further updates will be made available in 2007.

There has been significant progress in advancing the global pipeline of new TB drugs. Seven drugs, an unprecedented number, are currently in clinical development, paving the way for the introduction of a new TB regimen; the first for 40 years. In addition, six preclinical candidates and more than 30 discovery and basic translational research projects are in development in institutions around the world. The Working Group aims to continue to identify potential sites for clinical trials to ensure appropriate capacity for the clinical evaluation of new drug candidates for TB.

Members of the Working Group were updated on these advances in the drug development pipeline at the annual meeting of the Group at which the implications of the emergence of XDR-TB were also discussed. It

was agreed to establish a taskforce on XDR-TB to discuss recommendations for the TB drug development community

The Global Alliance for TB Drug Development, the housing agency of the Working Group on TB drug development, commissioned a study *Pathway to Patients*. This is a comprehensive global analysis of how today's TB drugs reach patients. It is based on the tenet that new cures will only be effective if they are available and affordable. The study analyses the pricing, purchasing, procurement and distribution mechanisms for first- and second-line TB treatments in 8 countries, and provides an estimate of the size of the global first-line TB drug market and will be released at the WHA in May 2007.

Regulatory approval

The Working Group cosponsored the Second Open Forum on "Regulatory Hurdles to TB Drug Development" in London, United Kingdom which aimed to increase representation from European and high burden country regulators and policy makers, as well as from the communities infected/affected by the disease. The Working Group Secretariat organized the event in coordination with the Bill and Melinda Gates Foundation, the TB Alliance, and Treatment Action Group. The Working Group aims to continue to facilitate dialogue on regulatory issues via the Open Forum series. The Global Alliance for TB drug development (the hosting agency for the Working Group on TB drug Development) presented a report at the Paris meeting of the Union.

Working Group on New TB Vaccines

Keeping the vaccine pipeline filled

Two vaccines moved to clinical trail stage:

- The MVA-85A vaccine from Oxford University (United Kingdom). It is based on vaccinia virus modified to deliver a *M. tuberculosis* antigen and was the first of the new TB vaccine candidates to commence phase II clinical trials in the Western Cape region of South Africa in summer 2006. This vaccine has already undergone extensive clinical testing in different populations (including tuberculin-positive and HIV-positive individuals) and different highly-endemic situations (in the Gambia, West Africa).
- Another vaccine candidate, based on an adenovirus vector expressing tuberculosis antigens, developed jointly by the Aeras Global TB Vaccine Foundation and Crucell Inc. of the Netherlands, entered an initial phase I clinical trial in October 2006.

Two development programmes, focusing on recombinant BCG vaccines, at the Max-Planck-Institute for Infection Biology (Berlin, Germany) and the Aeras Global TB Vaccine Foundation respectively advanced in their preclinical development and are expected to enter clinical evaluation in 2007.

Capacity at new TB vaccine trial sites

2006 has seen, through coordinated efforts of the Aeras Global TB Vaccine Foundation, the European–Developing Country Clinical Trials Platform (EDCTP) and the European Union's TBVAC initiatives amongst others, an expansion of geographical scope, by starting to build phase III trials sites outside South Africa, for example in Ethiopia, India and Uganda.

Availability of vaccine production capacity

Ensuring the availability of vaccine production capacity and scale-up received a major boost in 2006 by the establishment of a vaccine production plant for live bacterial vaccines and in particular BCG at the Aeras Global TB Vaccine Foundation's facility. This meets a critical need since the facilities for producing BCG (a live, infectious agent) are very limited, old and often incompatible with modern vaccine production technologies.

An enabling infrastructure

The Working Group elected Mr Michel Greco as its new Chairperson in March 2006. A major change implemented by Mr Greco has been the establishment of five task forces to:

- address definition and harmonization of laboratory and clinical parameters of TB vaccine research;
- reinforce clinical study sites capacity, especially in India and South Africa, to prepare for the future phase III trials;
- focus on strengthening discovery and translation research to keep the vaccine pipeline filled;
- study the economic aspects of TB vaccine development and introduction;
- provide a link with the overall advocacy, communications and social mobilization activities of the Stop TB Partnership.

Global Drug Facility

The Global Drug Facility (GDF) of the Stop TB Partnership has continued to procure an increasing number of patient treatments; in 2006 it approved access to 3.3 million life-saving anti-TB drug treatments. This meant approving 43 countries for new GDF grants and placing new drug orders worth US$ 29 million for its grant recipients. In addition to its grant recipients, 22 countries chose to procure anti-TB drugs through GDF using their own money or money from other donors. GDF delivered US$10.2 million worth of quality anti-TB drugs to these direct procurement customers.

A signal achievement during the year was that UNITAID (an innovative funding arrangement for financing drug procurement for HIV/AIDS, TB and malaria) selected GDF as its Programmatic Partner to supply anti-TB drugs for children. In addition GDF expanded its product catalogue to include second-line anti-TB drugs (for the treatment of MDR-resistant TB) through the merger of its procurement function with that of the Green Light Committee.

During the year GDF brokered technical assistance missions to 58 countries by drug management and TB experts. Drawn from members of the Stop TB Partnership, mission teams monitor the use of anti-TB drugs supplied by GDF while working with national programmes to address bottlenecks and weaknesses in their supply chain. Mission teams also work with programmes to calculate their future drug needs and develop a procurement plan.

Through workshops in Benin, France, and Kazakhstan, GDF provided crucial training to national and regional consultants on how to properly procure and manage anti-TB drugs. Such drug management workshops directly benefit TB control, but also teach skills that health-care workers can use when managing medicines and supplies for other health programmes.

In 2006, GDF received US$44 million from its donors. Its operations were certified as ISO 9001:2000 compliant for "provision of quality-assured anti-TB drugs and related services to eligible national TB control programmes". Development of its state-of-the-art information system continued apace, allowing GDF to monitor its services to countries. Key performance and impact indicators are reported regularly by GDF via its public web site and annual progress reports.

Resource mobilization and financial management

During 2006, efforts continued to shape a robust and effective policy dialogue with donors on the priorities and needs of the Stop TB Partnership. Closer relationships were developed with existing donors by providing regular progress reports on the performance of the Secretariat during the year. Donor commitments totalling US$42.8 million were signed with Bill and Melinda Gates Foundation, CIDA, the Governments of Norway, The Netherlands and USAID.

Looking forward, one of the challenges for the Stop TB Partnership will be to help partners in their efforts to secure funds for implementing their TB control activities, and coordinating potentially conflicting demands and mandates of partners as they gear-up to a much higher level of activity to deliver the Global Plan.

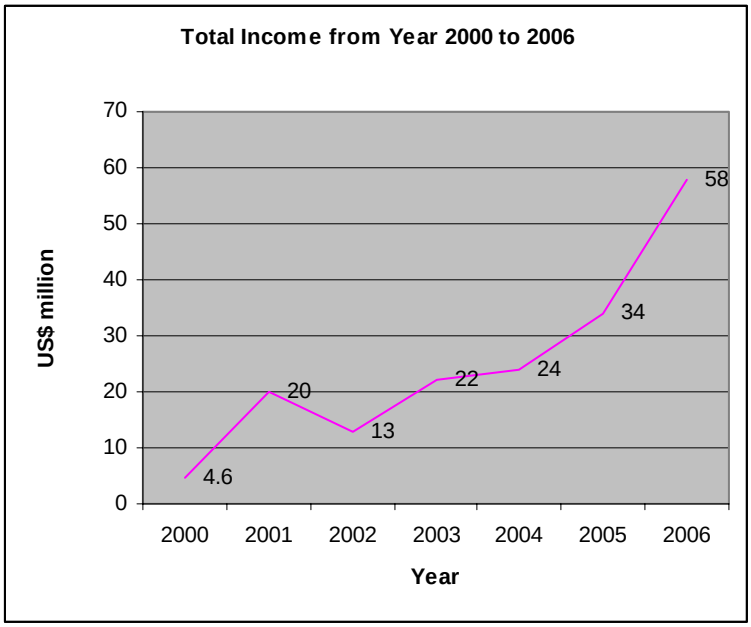
During 2006, the total income of the Partnership Secretarait was US$ 58 million a significant increase of 69% over 2005 (US$ 34.4 million). Of the total contributions received in 2006, US$ 54 million were channelled through the Stop TB Partnership Trust Fund. During the same period, the operating expenditure of the Secretariat was US$ 52.9 million resulting in a surplus of US$ 4 million after reserves. It should be noted that since 2000 the Partnership income has grown at a compound rate of 43.6% per annum resulting in a growth in income from US$ 4.6 million in 2000 to US$ 58 million in 2006 (Figure 3).

Contributions in-kind increased to US$ 3.74 million due, in part, to donations by Novartis of anti-TB drugs for Tanzania to the value of US$ 3.2 million.

Steps were taken to put in place better financial controls to reduce financial risk. As required by the financial policy approved by the Stop TB Coordinating Board reserves (up to 10% of income) should be built up. A first step was taken in this direction with $1.0 million placed in reserve. Interest totalling US$ 1.2 million, covering the period 2005 and 2006, was notified and credited to the Stop TB Partnership Trust Fund at WHO in January 2007.

2006 was the first year of the implementation of the workplan for the biennium 2006–2007. The implementation rate was 58% of the approved workplan.

Figure 3. Total income of the Stop TB Partnership Secretariat



Stop TB Partnership Financial Management Report

Statement of income and expenditure for the year ending 31 December 2006
(All figures in US$'000)

	Notes*	2005	2006
Income			
Voluntary contributions in cash			
Governments & their Agencies	1	29 859	50 268
Multilateral organizations	2	700	700
Foundations and others	3	470	2 059
Interest	4	0	1 280
Subtotal		**31 029**	**54 307**
Voluntary contributions in-kind			
Governments	5	169	13
Multilateral organizations and Foundations	6	547	504
In-kind contribution for drugs (Novartis)	7	2 605	3 226
Subtotal		**3 321**	**3 743**
Total income		**34 350**	**58 050**
Expenditure			
Partnership	8	3 211	5 791
Advocacy, Communication and Social Mobilisation		929	1 093
Global Drug Facility	9	30 196	43 346
General Management and Administration	10	2 324	2 740
Total expenditure		**36 660**	**52 970**
Transferred to reserves		**0**	**1,000**
Surplus/(deficit) of income over expenditure after transfer to/ from reserves	11	**(2 310)**	**4 080**

* see notes on following pages

Notes related to the statement of income and expenditure for the year ending 31 December 2006

US$ '000

Note 1
Voluntary contributions from Governments & their Agencies

	2005	2006
a) for the Global Drug Facility (GDF)		
CIDA	20 642	22 862
Norway	743	899
USAID	4 700	5 000
DFID	0	11 962
Subtotal	**26 085**	**40 723**
b) for the Partnership Secretariat		
CIDA for the ISAC initiative	351	0
CDC	182	176
USAID	640	1 433
DFID	176	5 870
Unspecified contributions from Governments allocated by WHO to Partnership[2]	2 425	227
The Netherlands	0	1 839
Subtotal	**3 774**	**9 545**
Total voluntary contributions from Governments & their Agencies	**29 859**	**50 268**

Note 2
Multilateral organizations

World Bank	700	700

[2] Unspecified contributions allocated by WHO to the Partnership in 2005 comprise contributions from Italy, the Netherlands and Switzerland. In 2006 it only comprises a contribution from Switzerland.

	US$ '000	
Note 3		
Foundations and others		
Kochon Foundation	100	100
Open Institute	200	0
RESULT	170	170
Bill and Melinda Gates Foundation	0	1 789
Subtotal	**470**	**2 059**
Note 4		
Interest		**1 280**
Note 5		
In-kind contributions from the Governments		
Netherlands	133	0
Norway	36	13
Sub total	**169**	**13**
Note 6		
In-kind contributions from Multilateral Organizations, Foundations and others		
Management Science for Health (service of staff) for GDF	188	125
WHO for partnership	359	379
Subtotal	**547**	**504**
Note 7		
Novartis contribution for drug procured for Tanzania	**2 605**	**3 226**
Note 8		
Expenditures		
National partnership coordination	300	540
Partnership building and management	606	1 061
Support to countries implementing the ISAC initiative	1 312	442
Governance	470	725
Working Groups	523	774[3]
Technical assistance for India	0	2 249
Subtotal	**3 211**	**5 791**

[3] Of the total amount allotted to the Working Groups in 2006, 28% remained unspent as of 31 December 2006.

	US$ '000	
Note 9		
Global Drug Facility expenditures		
Procurement of TB drugs [4]	28 367	41 344
Quality assurance and prequalification	123	84
Technical assistance monitoring and salaries	1 649	1 875
Advocacy and communications	57	43
Total	**30 196**	**43 346**

Note 10		
General management and administration costs		
Admin functions	797	799
WHO Programme Support Costs	1 527	1 941
Total	**2 324**	**2 740**

Note 11 Surplus of income over expenditure after transfer to reserves	
Money received in Dec 2006 therefore not obligated in 2006	1 643
Needed for planned activities for the first quarter of 2007	2 437
Total	**4 080**

[4] *GDF expenditure does not include the direct procurement totalling USD 10.2 million which is reported in GDF statement*