Stop TB Partnership
Key Performance Indicators
2016-2022

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GOAL 1: ADVOCATE, CATALYZE AND FACILITATE SUSTAINED COLLABORATION AND COORDINATION AMONG PARTNERS IN ORDER TO ACHIEVE THE TARGETS UNDER THE GLOBAL PLAN TO END TB 2018-2022 AND MOVE TOWARDS ENDING TB.	
1.1 (Sub-goal 1): Ensure TB is high on the political agenda through increased dialogue and engagement with political decision makers and influencers, and a strong unified community	
Indicator	Percentage of priority countries[1] that have aligned the targets of their national strategic plans with the UNHLM targets. ("political commitment").
Definition	"Aligned" here means that the NSP targets are either the same, or within +/- 20% of the globally modelled targets, with valid explanations for the variation.
Rationale for use	Measures political will and extent to which targeted advocacy and the highest level of political engagement and ownership are achieved at the country, regional, and global levels.
How it is measured	Numerator X 100% Denominator **Numerator:** Number of countries in which the NSP targets are aligned with UNHLM TB treatment targets on Stop TB website **Denominator:** Number of countries who are in the list of priority countries (total n=27)
Baseline and Target(s)	**Baseline:** 2015 (0%) **Targets:** 2016 (25%); 2017 (50%); 2018 (65%); 2019 (80%); 2020 (90%); 2021 (90%); 2022 (90%)
Data source	Specific source document will be a country´s National Strategic Plan
Limitations	1. Countries prepare national strategic plans once every 3 to 5 years, hence this indicator will change only for a few countries each year. 2. In the event of substantial changes to WHO estimates of TB incidence due to new information, the result of this indicator may need to be interpreted with additional qualitative information.

[1] See Annex One for list of 27 priority countries.

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1.2 (Sub-goal 2): Increase the financial resources available for implementation of the Global Plan 2018-2022	
Indicator	Percentage of countries with an increase in national level for funding for TB ("national funding").
Definition	National level funding defined as domestic resources and overseas development assistance (ODA) to country.
Rationale for use	Directly measures annual changes in national financing (domestic and ODA) mobilized for implementation of the Global Plan 2018-2022.
How it is measured	Numerator X 100% Denominator ***Numerator:*** Number of priority countries* that have an increase in national finances (domestic and ODA) for TB as compared with previous year ***Denominator:*** Number of priority countries* (n= 27) * Priority Countries[2]
Baseline and Target(s)	**Baseline:** 2015 (39%) **Targets:** 2016 (40%); 2017 (45%); 2018 (50%); 2019 (60%); 2020 (80%); 2021 (80%); 2022 (80%) These targets imply that in 80% of high burden countries, the budget for TB at national level from all sources will increase in 2021 compared to 2020; also 80% of countries will have further increases in their budget in 2022 compared to 2021.
Data source	WHO TB database on government and international donor financing (data reported by NTPs) (WHO)
Limitations	Financial data reported by NTPs is likely to be an under-estimation of international donor funding, as some international donor funding may be channelled directly to other entities (rather than through national systems). Also, NTP reported data will very likely not include private sector funding, or funding for communities, key populations or vulnerable groups. In this way, they will likely underestimate financing available for TB at the national level. Due to availability of data and intensive effort to collect, verify and analyse data, only a selection of countries will be chosen to measure this indicator.

[2] See Annex One for list of 27 priority countries.

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1.3 (Sub-goal 3, objective D): Strengthen TB community systems and responses through the Challenge Facility for Civil Society and other initiatives and platforms	
Indicator	Percentage of countries that have national strategic plans (NSPs) with components to strengthen TB community systems including gender, human rights, stigma, and/or grassroots activities ("community systems")
Definition	The inclusion of TB community systems strengthening components will be measured by reference to at least one gender, human rights, stigma, and/or grassroots activity in the TB NSP.
Rationale for use	Community approaches to TB, particularly human rights and gender approaches, are relatively new areas of work in TB. The actual inclusion of gender, human rights, stigma, and/or grassroots activities in the TB NSP – the measure for this indicator - demonstrates a commitment to action.
How it is measured	Numerator X 100% Denominator ***Numerator:*** Total number of priority countries with TB NSPs that have mentioned the four components (gender, human rights, stigma and grassroots activities) in each of the five criteria: inclusion, assessment, implementation, monitoring and budgeting ***Denominator:*** Number of selected priority countries (n=27) multiplied by 20 (i.e., 4 components times 5 criteria[3])[4]
Baselines and Target(s)	**Baseline:** 2015 (2%) **New Baseline:** 2019 (50%) **Targets:** 2017 (50%); 2019 (60%); 2021(55%); 2023 (65%)
Data source	TB National Strategic Plans 2021 reporting will be based on 2020 data and 2023 reporting based on 2022 data
Limitations	This indicator may underestimate TB community systems strengthening activities, as some community strengthening activities (that are either underway or being planned) may not be included in national strategic plans. For example, costed TB CRG Action Plans may be separate from the NSP itself; therefore, would not necessarily be captured through the current NSP.

[3] The 5 criteria:

Criteria 1	*Criteria 2*	*Criteria 3*	*Criteria 4*	*Criteria 5*
Number of NSPs that mentioned the specific component	Number of NSPs conducted an assessment on the component	Number of NSPs with specific activities for implementation	Number of NSPs with specific indicators for the component	Number of NSPs with a budget line allocated for the component

[4] See Annex One for list of countries.

GOAL 1: ADVOCATE, CATALYZE AND FACILITATE SUSTAINED COLLABORATION AND COORDINATION AMONG PARTNERS IN ORDER TO ACHIEVE THE TARGETS UNDER THE GLOBAL PLAN TO END TB 2018-2022 AND MOVE TOWARDS ENDING TB.	
1.4 (Sub-goal 3, Objective C): Maximize the impact of the Global Fund's TB portfolio towards reaching the Global Plan targets	
Indicator	Percentage of Global Fund TB funds disbursed ("disbursement").
Definition	Disbursement defined as actual disbursements versus forecasted disbursement.
Rationale for use	Stop TB does extensive work with the Global Fund Secretariat to ensure that the Global Fund commits adequate resources to countries and the countries utilize these funds in a manner that maximizes impact. Absorption of funds by countries is a key factor in translating funds into impact.
How it is measured	Numerator X 100% Denominator **Numerator:** Cumulative disbursements during the implementation cycle for TB grants and TB/HIV grants in priority countries (2018-2020 or 2021-2023) **Denominator:** Disbursement forecast for the implementation cycle for TB grants and TB/HIV grants in priority countries (2018-2020 or 2021-2023) (n=27)[5]
Baseline and Target(s)	**Baseline:** 38% was disbursed by mid-2016 during the funding cycle 2014-2017 **New Baseline**[6]**:** 80% disbursed for implementation cycle 2014-2017 **Target:** Reaching 80% disbursed at the end of 2017 and 90% disbursed at the end of 2021. 2022 (30% disbursement by end of 2021, for new grants in the cycle 2021-2023) The 2022 target is lower because Global Fund starts a new grant implementation cycle in 2021. The first year of the three-year grant will be implemented in 2021, and therefore, the target for 2022 was kept at 30% disbursement of the overall implementation cycle amount.
Data source	Global Fund grant management and disbursement data
Limitations	In a few cases when the timing of grant signatures with respect to the funding cycle varies, it can become difficult to interpret the data on disbursements. For such cases qualitative explanations will be required for correct interpretation of the KPI. The disbursement of funds by the Global Fund does not ensure that funds will be expended by the country, that they will be used appropriately or have the intended impact. But the monitoring from Global Fund of expenditure should ensure that disbursed funds do not remain unexpended for a long time. Many of the issues which delay disbursement are well outside the influence of the Partnership (e.g., whether or not the country has signed, issues around audit or financial management). TB/HIV joint Global Fund grants in a few countries makes it difficult to disaggregate disbursements that are purely for TB. While recognizing that inclusion of the HIV portion of the grant may skew the results, given that these can be an important source of TB funding, TB/HIV grants will also be included in the calculation.

[5] See Annex One for list of countries.

[6] Implementation cycle 2014-17 was taken as a baseline because full data is available for disbursement rate.

GOAL 2: SUPPORT THE DEVELOPMENT, REPLICATION AND SCALE-UP OF INNOVATIVE APPROACHES (INCLUDING IN THE ROLL-OUT OF NEW TOOLS) TO OVERCOME SYSTEMIC BARRIERS IN THE FIGHT AGAINST TB	
2.1 (Objective A): Promote innovation in TB service delivery and new tools through TB REACH and other initiatives.	
Indicator	Percentage of funding available for TB research and development (R&D) versus identified need ("R&D funding")
Definition	The overall funding need for new tools is defined in the Global Plan to End TB 2018-2022. The funding available is calculated through an R&D Funding Annual Report.
Rationale for use	This indicator measures the success of advocacy efforts for R&D funding. Development of new tools is critical to "bend the curve" and achieve the targets as set out in the End TB Strategy. This will require significant investment as defined in the Global Plan to End TB.
How it is measured[7]	Numerator X 100% Denominator ***Numerator:*** Funding available for TB R&D ***Denominator:*** Funding needed for TB R&D per year as defined in the Global Plan to End TB 2018-2022
Baseline and Target(s)[8]	**Baseline:** 2014 (674 million) **Targets:** 2017 (increase annual funding to 75%*); 2018 (increase annual funding to 100%*); 2019 (exceed annual funding by 25%*); 2020 (exceed annual funding by 50%*); 2021 (100% of the 2 billion USD annual need expressed in the UNHLM political declaration); 2022 (100% of the 2 billion USD annual need expressed in the UNHLM political declaration)[9] *% of US$ 1.8 billion annualized need as per the Global Plan
Data source	For "funding available" – R&D funding annual report. For identified need – UNHLM Political Declaration on TB, October 2018
Limitations	Although R&D is a critical element of the End TB strategy, the Secretariat has limited impact on global R&D funding for TB. The funding of Secretariat activities does not allow for the development, launch and roll-out of a global advocacy campaign on R&D development for TB.

[7] The measurement excludes roll-out costs.

[8] Targets were set by the Stop TB Partnership Research Working Groups.

[9] The target of 100% is taken from the UNHLM commitment and kept to report gaps against it.

GOAL 2: SUPPORT THE DEVELOPMENT, REPLICATION AND SCALE-UP OF INNOVATIVE APPROACHES (INCLUDING IN THE ROLL-OUT OF NEW TOOLS) TO OVERCOME SYSTEMIC BARRIERS IN THE FIGHT AGAINST TB	
2.2 (Objective A): Promote innovation in TB service delivery and new tools through TB REACH and other initiatives.	
Indicator	Percentage of TB REACH supported projects demonstrating an increase in case detection and/or improved treatment outcomes ("improved service delivery").
Definition	An increase is defined identification of additional TB cases and/or improved treatment outcomes versus during the baseline period.
Rationale for use	This measure enables the Secretariat to determine whether innovative projects funded by TB REACH contribute to strengthening TB service delivery as measured through the identification of additional TB cases and improved treatment outcomes. In addition, TB REACH projects are evaluated using a robust standardized methodology, with various measures taken to ensure data quality and assess attribution (e.g. intervention areas are compared with control area and adjustments made for secular trends, where appropriate).
How it is measured	Numerator X 100% Denominator ***Numerator:*** Number of TB REACH projects funded between 2017-2020 that succeed in identifying additional TB cases and/or improved treatment outcomes than during the baseline period (country specific) ***Denominator:*** Number of TB REACH projects funded between 2017-2020
Baseline and Target(s)	Baseline: 0 Target: 2020 (80%); 2021-2022 (80%)
Data source	Project reports from each TB REACH funding Waves 5 and 6 using validated data by external M&E.
Limitations	Initial funding for Wave 5 will be made in Q1 2017. Due to the timing of the TB REACH funding and evaluation periods this indicator cannot be reported on annually, but only after the evaluation of the respective waves of TB REACH projects are completed and all data have been validated (on average 18 months from baseline data collection to final validated report). Data availability cannot be predicted or linked to calendar years or board meetings. It is likely that only 2 complete measurements (for Wave 5 and Wave 6) will happen during the 2017-2020 period. However, interim reports from ongoing grants can be provided after at least 6 months of project implementation.

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2.3 (Objective B): Generate evidence-based practice and knowledge sharing around the implementation of innovative approaches in TB care delivery and the roll-out of new tools.	
Indicator	Percentage of relevant WHO policy guidance referencing TB REACH supported projects ("policy influence").
Definition	Contribution to advancing policy defined by references to TB REACH supported projects or articles in WHO policy guidance documents and/or TB REACH participation in policy development and meetings.
Rationale for use	WHO guidance shapes national TB policy and guidelines as well as donor policies and funding priorities. Influencing WHO policy guidance thus can have broad impacts on the uptake and funding of effective innovative approaches piloted by TB REACH at the country level.
How it is measured	Percentage of relevant WHO policy guidance documents that refer to evidence generated through TB REACH, as compared with 2015 baseline. Measured by direct citations to articles related to TB REACH supported projects and/or TB REACH participation in the policy development and review meetings.
Baseline and Target(s)	**Baseline:** 2010-15 (17%) (n=17) **Target:** 2016-2020 (50%); 2021-2022 (50%)
Data source	WHO TB policy guidance documents (WHO)
Limitations	TB REACH may generate evidence which influences WHO policy development, but which is not referenced as such. Given the limited number of policy guidance documents released by WHO each year, this indicator may also have limited data points for input. Also, as TB REACH does not support randomized clinical trials, it is less likely TB REACH would be cited directly in WHO guidelines or graded evidence. Consideration must also be given to the time between the publication of results and the generation of WHO policy, which can often be significant.

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2.4 (Objective C): Support the adoption and scale-up of effective, innovative approaches from TB REACH and other initiatives by mobilizing domestic and/or external funding.	
Indicator	Percentage of approaches funded by TB REACH that are part of national plans and/or are being scaled up ("scale up of TB REACH approaches").
Definition	"Scale up" defined as included in national plans and/or are being scaled up through domestic or external funding such as the Global Fund.
Rationale for use	Provides a direct measure of approaches funded by TB REACH that are being incorporated into national strategic plans and/or being scaled up through the domestic or other external funding (non-TB REACH). Active collaboration with the Global Fund is already initiated to formalize this process.
How it is measured	$\frac{\text{Numerator}}{\text{Denominator}} \times 100\%$ ***Numerator:*** Approaches funded by TB REACH are part of national plans and/or being scaled up through domestic and/or or external funding ***Denominator:*** All approaches funded by TB REACH
Baselines and Target(s)	**Baseline:** 2010-2015 (21%) **Target:** 2016-2020 (33%); 2021-2022 (33%)
Data source	Grantee reports, NSPs and Global Fund concept notes/applications
Limitations	This does not capture the quality or effectiveness of the approaches/ programmes being scaled up or other factors (e.g. political influence) that may impact national decisions to scale up. It also may or may not capture TB REACH approaches that are adopted or being scaled up in countries that have not been funded by TB REACH. Also, given that the purpose of TB REACH is to innovate, not all approaches will be successful or merit national scale up, hence the target of 33% (or one-third) – this is an increase on the approximately 20% which were scaled-up from Waves 1-4. This indicator will often come with some delay as even successful approaches take some time to be incorporated into national plans or other funding.

GOAL 3: **FACILITATE** WORLDWIDE, EQUITABLE ACCESS TO TB MEDICINES AND DIAGNOSTICS INCLUDING NEW TOOLS, ACROSS SECTORS	
3.1 (Objective A): Manage and coordinate market activities across all stakeholders for the full portfolio of TB medicines, regimens and diagnostics	
Indicator	Number of GDF TB market roadmaps endorsed by stakeholders ("market coordination").
Definition	Market roadmaps are brief documents that describe market inefficiencies as well as agreed-upon objectives, interventions, and targets. Market roadmaps will be developed in consistent formats for specific products or for cross-cutting initiatives.
Rationale for use	Stakeholder endorsement demonstrates recognition of GDF's thought leadership and coordination role with regard to market activities. Coordination of stakeholders should ensure all stakeholders are working toward common goals and should minimize duplication of effort.
How it is measured	***Stakeholders*** include those organizations who are members in the GDF TB Procurement and Market-Shaping Action Team. ***Roadmaps*** will be developed for a sub-set of GDF products or initiatives "as tracers" for overall performance. Roadmaps may not be drug specific. For example, the first coordinated activity will likely be to agree on and implement a prioritization scheme to send the right signals to suppliers on the medicines, formulations of highest priority. ***Endorsement*** will be measured by formal sign off for roadmaps, as noted in meeting minutes, by the GDF TB Procurement and Market-Shaping Action Team.
Baseline and Target(s)	**Baseline:** 2015 (0) **Targets (cumulative):** 2016 (1); 2017 (3); 2018 (4); 2019 (5); 2020 (6); 2021 (10); 2022 (12)
Data source	GDF Order Management System data Market data from non-GDF sources Published papers and reports
Limitations	Stakeholder endorsement may not preclude key actors from continuing to operate or make decisions based on their own institutional interests in a manner that is inconsistent with stakeholder consensus or in a manner that duplicates efforts.

GOAL 3: **FACILITATE** WORLDWIDE, EQUITABLE ACCESS TO TB MEDICINES AND DIAGNOSTICS INCLUDING NEW TOOLS, ACROSS SECTORS	
3.2 (Objective B): Develop state of the art business intelligence and data driven approaches through early adoption of cutting-edge technology	
Indicator	Percentage of tracer medicines with accurate demand forecasts ("forecast accuracy")
Definition	Demand forecasts are defined as annual forecasts provided to suppliers during the tender process. Accuracy is defined as order volumes placed with suppliers that are at least 80% of the annual forecasted volumes for the one-year tender period. Based on current use and latest WHO treatment guidelines the tracer list consists of medicines used in treatment of drug resistant tuberculosis (DR-TB). The current tracer list includes WHO-recommended Group A and B medicines. (levofloxacin, moxifloxacin, bedaquiline, linezolid, clofazimine, cycloserine). The tracer medicines list may be reassessed, as needed, due to rapid changes in the evidence for TB treatment efficacy and introduction of new medicines and their combinations to treatment.
Rationale for use	Reliable forecasts are a key business intelligence tool for market shaping as they enable matching of supply and demand, and drive industry's investment decisions and production planning. Second line drugs have been chosen as tracers because these markets are particularly fragile and thus accuracy of forecasting is particularly critical.
How it is measured	Annual review of forecast volumes versus actual order volumes placed with suppliers for a sub-set of GDF medicines "as tracers" for overall performance.
Baseline and Target(s)	**Baseline:** 2015: 75% **Targets:** 2016 (75%) 2017 (75%), 2018 (65%), 2019 (65%), 2020 (65%); 2021 (65%); 2022 (65%)
Data source	GDF forecasts provided with invitation to Bid documents during the tender process. Procurement Agent data on actual order volumes placed with suppliers. The GDF Order Management System (OMS) data. Aggregated quantification files from priority countries.
Limitations	See note above on potential need to revise list of tracer medicines based on new guidelines. GDF currently has limited advance intelligence on development or revision of WHO guidelines to adjust annual forecasts, accordingly. Similarly, GDF visibility on progress against national strategic plans has improved in priority countries but remains limited in non-priority countries and when procuring with domestic financing and/or domestic procurement procedures. Advance intelligence on WHO guidelines changes and credible time-bound plans for country adoption of these changes is critical to developing accurate demand forecasts.

GOAL 3: **FACILITATE** WORLDWIDE, EQUITABLE ACCESS TO TB MEDICINES AND DIAGNOSTICS INCLUDING NEW TOOLS, ACROSS SECTORS	
3.3 (Objective C): Undertake strategic procurement and executive innovative logistics solutions for TB medicines and diagnostics	
Indicator	Percentage of On-Time In-Full (OTIF) deliveries for second-line drugs (SLDs) ("delivery performance").
Definition	OTIF measures the success at delivering exactly what the customer ordered in the time it was supposed to be delivered. It measures whether the supply chain was able to deliver the expected product (reference and quality) in the quantity ordered by the customer at the expected time.
Rationale for use	OTIF is the industry standard for measurement of delivery performance and is the key indicator used by the Global Fund to monitor its performance. As per the StopTB/GDF-Global Fund MoU, the two parties have aligned on reporting this indicator. SLDs are chosen given the long lead times and challenges with co-packing multiple orders for multiple drugs into a single shipment.
How it is measured	OTIF is expressed as a percentage: % OTIF = % of all deliveries made OTIF = (# OTIF deliveries ÷ total # deliveries) x 100 This will be measured for all second line drugs.
Baseline and Target(s)	**Baseline:** 2015 (75%) **Targets:** 2016 (75%); 2017 (75%); 2018 (75%); 2019 (75%); 2020 (75%); 2021 (75%); 2022 (75%)
Data source	GDF Order management system data
Limitations	OTIF measures supply-side performance only (GDF, supplier, procurement agent) but does not measure demand-side performance (e.g., buyer quantification and volumes ordered).

GOAL 3: **FACILITATE** WORLDWIDE, EQUITABLE ACCESS TO TB MEDICINES AND DIAGNOSTICS INCLUDING NEW TOOLS, ACROSS SECTORS	
3.4 (Objective D): Accelerate the uptake of new medicines, regimens, and diagnostics using the GDF "launch pad" in close collaboration with TB REACH and Stop TB Partnerships Working Groups on new TB medicines	
Indicator	Country uptake of: • Bedaquiline (BDQ), • Delamanid (DLM), • Pediatric fix-dose combination (FDCs) formulations for DS-TB, • 2016 WHO-recommended Shorter Regimen for DR-TB treatment (e.g., kanamycin-based standard shorter regimen) • Child-friendly formulations for DR-TB treatment (e.g., levofloxacin 100mg dispersible tablets DT, moxifloxacin 100mg DT, cycloserine 125mg mini-capsules, ethambutol 100mg DT, pyrazinamide 150mg DT, ethionamide 125mg DT) • 2019 WHO-recommended all-oral longer regimen for DR-TB treatment • 2020 WHO-recommended bedaquiline-based all-oral shorter regimen for DR-TB treatment • Rifamycin-based short regimen for TB Preventative Treatment
Definition	Uptake is defined as new medicines/regimens introduced in 26 GDF priority countries for delamanid and 2016 WHO-recommended shorter regimens, 25 for bedaquiline and pediatrics via GDF.[10] 53 GDF priority countries (26 Tier 1 and 27 Tier 2)[11] for child-friendly formulations for DR-TB, 2019 and 2020 WHO recommended regimens for DR-TB treatment and LTBI. GDF will also report the volume or estimated number of new treatments supplied to priority countries.
Rationale for use	KPI focuses on GDF role in providing access to new tools to facilitate expedited introduction (medicines, regimens,) as they become available/recommended.
How it is measured	Indicator would be tracked separately across the different medicines and regimens as a ratio: # GDF priority countries that have introduced new TB medicines and treatments regimens/ # GDF priority countries. GDF will also report the estimated number of treatments supplied to countries for new tools when treatments can be calculated from procurement data. For other tools, volumes supplied will be reported.

[10] GDF priority countries: Afghanistan, Bangladesh, Cambodia, Dem Rep Congo, Ethiopia, India, Indonesia, Kazakhstan, Kenya, Kyrgyzstan, Malawi, Mozambique, Myanmar, Nigeria, Pakistan, Philippines, South Africa, South Sudan, Tajikistan, Tanzania, Uganda, Ukraine, Uzbekistan, Viet Nam, Zambia, Zimbabwe.

[11] GDF priority countries: Afghanistan, Angola, Armenia, Azerbaijan, Bangladesh, Belarus, Benin, Burkina Faso, Cambodia, Cameroon, Central African Rep, Chad, Cote d´Ivoire, Dem Rep Congo, Ethiopia, Eswatini, Georgia, Ghana, Guinea, Haiti, India, Indonesia, Kazakhstan, Kenya, Kyrgyzstan, Lesotho, Liberia, Malawi, Mali, Morocco, Mozambique, Myanmar, Nepal, Niger, Nigeria, Pakistan, Papua New Guinea, Philippines, Rep Moldova, Rwanda, Senegal, Sierra Leone, Somalia, South Africa, South Sudan, Tajikistan, Tanzania, Uganda, Ukraine, Uzbekistan, Viet Nam, Zambia, Zimbabwe.

Baseline and Target(s)	Bedaquiline • **Baseline:** 2015 (11/25); **Targets:** 2016 (20/25); 2017-2022 (25/25) Delamanid • **Baseline:** 2015 (0/26); **Targets:** 2016 (10/26); 2017(15/26); 2018-2022 (26/26) Pediatrics • **Baseline:** 2015 (0/25); **Targets:** 2016 (12/25); 2017 (24/25); 2018-2022 (25/25) Child-friendly formulations for DR-TB treatment (e.g., levofloxacin 100mg dispersible tablets [DT], moxifloxacin 100mg DT, cycloserine 125mg mini-capsules, ethambutol 100mg DT, pyrazinamide 150mg DT, ethionamide 125mg DT) • **Baseline:** 2017 (0/53) • **Targets Tier 1:** 2021 (100% - 26/26) • **Targets Tier 2:** 2021 (100% - 27/27) 2019 WHO-recommended all-oral longer regimen for DR-TB treatment • **Baseline:** 2018 (0/53) • **Targets Tier 1:** 2021 (90% - 23/26); 2022 (100% - 26/26); • **Targets Tier 2:** 2021 (90% - 24/27); 2022 (100% - 27/27) 2020 WHO-recommended bedaquiline-based all-oral shorter regimen for DR-TB treatment • **Baseline:** 2019 (0/53) • **Targets Tier 1:** 2021 (75% - 20/26); 2022 (100% - 26/26) • **Targets Tier 2:** 2021 (60% -16/27); 2022 (90% - 24/27) Rifamycin-based short-course regimens for TB Preventative Treatment (includes 3RH, 3HP, 1HP, 4R in populations not living with HIV) • **Baseline:** 2019 (0/53) • **Targets Tier 1**: 2021 (40% 11/26); 2022 (70% 18/26) • **Targets Tier 2:** 2021 (25% - 7/27); 2022 (50% 13/27)
Data source	• The GDF Order Management System data • Country-specific TB medicines quantification files • Missions/Joint Programme Review reports • Regular communications between RTAs/CSOs and country programmes
Limitations	For new, single-source tools with limited country-eligibility lists for access pricing, the denominator may change with changes in eligibility. GDF has more in–country influence in formulation changes than new drug or regimen introduction as the latter require national guideline and policy changes typically out of the remit of GDF. GDF´s visibility on planned WHO guideline changes has increased allowing GDF to prepare countries for changes; however, it remains limited for preparing suppliers based on product lifecycle and development timelines. Treatments procured are back calculated based on procurement data and assumptions. Where treatment regimens cannot be calculated, volumes procured will be reported.

GOAL 4: ENSURE THE OPTIMAL AND EFFICIENT FUNCTIONING OF THE SECRETARIAT	
4.1 (Objective A): The Secretariat, well supported by its hosting agency, is lean, cost efficient, operates and is managed in an effective manner	
Indicator	Operating costs as share of total expense ("operating efficiency")
Definition	This indicator measures the percent of total operating costs (hosting agency and Secretariat) vis-à-vis total expense, including an additional 1% coordination levy introduced by UN General Assembly (resolution 72/279) applied to all engagements signed with partners starting 1 January 2021.
Rationale for use	This indicator measures how efficiently the organization uses it resources to achieve its strategic and programmatic goals and objectives.
How it is Measured	"Operating costs" defined as total hosting agency costs as well as Secretariat fixed and core human resource costs: Numerator X 100% Denominator ***Numerator***: PSC, hosting agency, (CMDC and LMDC) and Secretariat fixed and core human resource costs ***Denominator:*** Total expenditure and disbursements on an annual basis, including for GDF, TB REACH, and the Challenge Facility for Civil Society. PSC (programme support costs) CMDC (centrally managed direct costs) LMDC (locally managed direct costs) Secretariat fixed costs include rent, utilities, IT, insurance, and phones. Cross-cutting positions: 11 staff positions including the Executive Director and Deputy Executive Director. These positions are neither programme nor project specific, but rather provide broad support across the Secretariat's various programme priorities. Operating costs are to be calculated based upon actual expenditures (not approved budgets), using year-end expenditure reports.
Baseline and Target(s)	**Baseline:** 2015 (12%) **Target:** 2016-2020 (<13%); 2021-2022 (<13%)
Data source	Annual work plan and budget (Secretariat)
Limitations	Although the operating expense ratio provides a reference point for overall efficiency, it is not a comprehensive measure as does not measure quality or indicate whether the Secretariat resources are being implemented effectively. One risk is the unforeseen expenses, such as the 1% levy introduced unexpectedly by the UN General Assembly applied to all engagements signed with partners starting 1 January 2021 and that can be increased without notice.

GOAL 4: ENSURE THE OPTIMAL AND EFFICIENT FUNCTIONING OF THE SECRETARIAT	
4.2 (Objective B): The Secretariat is adequately staffed, is gender balanced and staff are drawn from diverse cultural backgrounds.	
Indicator	Vacancy rate
Definition	Percent of full-time positions (FTE) identified in annual work plan that have been not filled in comparison to total FTEs identified as needed in annual work plan.
Rationale for use	Adequate staffing is required to deliver on the goals and objectives of the Stop TB partnership. Staffing levels impact organizational performance and are an important contextual factor when considering progress (or lack thereof) on other KPIs.
How it is measured	Numerator X 100% Denominator ***Numerator:*** Number of full-time positions (FTE) identified in annual work plan that have not been filled ***Denominator:*** Number of full-time positions (FTE) identified in annual work plan
Baseline and Target(s)	**Baseline:** 2015 (20%) **Target:** 2016-2020 (<7 percent vacancy rate -benchmarked against GAVI); 2021-2022 (<7 percent vacancy rate -benchmarked against GAVI)
Data source	Annual cumulative expenditure report (Secretariat)
Limitations	The weakness of this measure is that it does not address performance of staff or workload. Also there is a risk that Secretariat may define staffing needs conservatively based upon available funding, rather than staffing needs based upon the work plan.

GOAL 4: ENSURE THE OPTIMAL AND EFFICIENT FUNCTIONING OF THE SECRETARIAT		
4.3 (Objective C). The Secretariat has systems in place for managing financial resources and risk, is substantially funded through a number of donors committing to multi- year grants.		
Indicator	Number of donors and flexibility of funding ("donor diversity").	
Definition	Total number of donors that contribute to the Stop TB Partnership Secretariat and percentage of un-earmarked funds.	
Rationale for use	This measure enables the Secretariat to assess whether there is sufficient diversity in its donor base, and whether the proportion of un-earmarked funds is increasing, decreasing, or remaining static over time. Diversity of the donor base is critical for the long-term viability and sustainability of the partnership, as relying heavily on any single donor enhances the financial vulnerability of the partnership. Percentage of funds that are not earmarked gives the partnership the flexibility to fund strategy priorities and develop new business areas.	
How it is measured	Total number of donors *Total number of donors contributing financial resources through the Secretariat*	Numerator X 100% Denominator Percent of un-earmarked funds ***Numerator:*** *Amount of funding received by Stop TB Partnership that is not earmarked* ***Denominator:*** *Total amount of funding received by STOP TB Partnership*
Baseline and Target(s)	**Baseline:** 2015 (11 donors) **Target:** 2020 (15 donors); 2021-2022 (15 donors)	**Baseline:** 2015 (5%) **Target:** 2020 (10%); 2021-2022 (10%)
Data source	Stop TB donor agreements (Secretariat)	
Limitations	This indicator does not provide insights into the relative size of donor contributions or diversity of activities funded by any given donor.	

GOAL 4: ENSURE THE OPTIMAL AND EFFICIENT FUNCTIONING OF THE SECRETARIAT	
4.4 (Objective D): Governance mechanisms of the Stop TB Partnership operate in an efficient, effective and transparent manner (including the ~~Coordinating~~ Board, Executive Committee, Finance Committee, as well as any other Ad-Hoc Committees of the Board)	
Indicator	Timely distribution of governance documents ("timeliness").
Definition	Percentage of documents that are distributed to Board at least 7 days in advance of meetings. Documents are defined as the agenda and supporting materials for agenda sessions.
Rationale for use	This indicator measures the efficiency and timeliness of the Secretariat in distributing meeting documents and serves as a proxy for the extent to which there is alignment on agenda, key decision points, etc between the Board and Secretariat leadership. Additionally, if documents are distributed in advance, it increases the likelihood that Board members have sufficient time to review and reflect upon documents and/or share with constituents for inputs, enhancing effectiveness of representational process.
How it is measured	Numerator X 100% Denominator ***Numerator***: Number of Board documents distributed at least 7 days in advance of meetings ***Denominator***: Number of Board meeting documents
Baseline and Target(s)	**Baseline:** 2015: 30% **Targets:** 2016 (40%); 2017 (50%); 2018 (65%); 2019 (80%); 2020 (90%); 2021 -2022 (90%)
Data source	Email records of Board documents shared (Secretariat) and List of Documents (website) shared with the Board that indicates the dates of release of each document.
Limitations	The timely distribution of documents does not ensure quality of documentation or that members will share with their constituents for feedback or that members will review materials in advance.

GOAL 4: ENSURE THE OPTIMAL AND EFFICIENT FUNCTIONING OF THE SECRETARIAT	
4.5 (Objective E): Demonstrate, strengthen, and share the Secretariat's clear added value and impact	
Indicator	Partner satisfaction rating of Secretariat Support ("partner satisfaction").
Definition	Satisfaction of partners as measured by annual survey to partners (>2000 partners in 109 countries). This is intended to serve as a proxy measure for quality of Secretariat support.
Rationale for use	The Stop TB Partnership is a unique partnership organization that seeks to align a wide range of constituencies and partners across the world in the fight against TB. The key to retaining partners and constituents – and attracting new ones – is knowing what they need and value, how the Partnership can fill those needs, and what they think of the Partnership. Given the large size and broad scope of the partnership, maintaining individual or personal interaction with each partner is difficult. One of the best ways to keep in tune with partners and assess added value is by conducting annual partner satisfaction surveys.
How it is measured	The Stop TB Partnership administers an annual partner survey, to assess and improve its role in aligning, catalyzing, and facilitating the role of partners in the global effort against TB. The satisfaction questions are measured along a likert scale (0- n/a; 1= completely dissatisfied; 2: dissatisfied, needs major additional work; 3= OK needs only additional minor work; 4= satisfied, doing well; 5=completely satisfied, more than meets my expectations). Responses to questions gauging partners' satisfaction across 3 domains (communication tools, advocacy support, and CRG support) will be used to track this indicator over time. The percentage of 4s (satisfied) and 5s (completely satisfied, more than meets my expectations) will be added for each domain to measure satisfaction.
Baseline and Target(s)	**Baseline:** (2015): n/a Communication support and tools: 70% Advocacy support: 52% CRG support: 43% **Targets:** will be reported as met/not met 2021 (Satisfaction rating of 80 % in 3 core domains of Stop TB support to partners – Communication support and tools, Advocacy support, CRG support) 2022 (Satisfaction rating of 80 % in 3 core domains of Stop TB support to partners – Communication support and tools, Advocacy support, CRG support)
Data source	Annual partner survey data and report
Limitations	Satisfaction surveys are subject to non-response bias (how those who choose not to participate compare with those who choose to participate) and response bias (social desirability/favorable response bias). Low response rates are a particular challenge and may undermine the representativeness of the views presented. In addition, true assessment of 'added value" would require a "counterfactual". Given this is not possible, "perceived satisfaction" with services provided by the Secretariat is being used as a proxy indicator.

ANNEX ONE: LIST OF PRIORITY COUNTRIES

27 priority countries in total[12]

PRIORITY COUNTRIES		
Afghanistan	Kazakhstan	South Africa
Bangladesh	Kenya	Tajikistan
Cambodia	Kyrgyzstan	Tanzania
Cameroon	Malawi	Uganda
DRC	Mozambique	Ukraine
Ethiopia	Myanmar	Uzbekistan
Ghana	Nigeria	Vietnam
India	Pakistan	Zambia
Indonesia	Philippines	Zimbabwe

[12] Countries that are in the priority list of the two main external donors for TB globally.

ADDITIONAL INDICATORS AND RESULTS FOR ACCELERATED UPTAKE OF NEW MEDICINES, REGIMENS, AND DIAGNOSTICS USING THE GDF "LAUNCH PAD" IN CLOSE COLLABORATION WITH TB REACH AND STOP TB PARTNERSHIPS WORKING GROUPS ON NEW TB MEDICINES

KPI 3.4: Measures and Report of additional Performance Indicators		
Indicator	Country uptake of: • 2016 WHO-recommended Shorter Regimen for DR-TB treatment (e.g., kanamycin-based standard shorter regimen) • Child-friendly formulations for DR-TB treatment (e.g., levofloxacin 100mg dispersible tablets DT, moxifloxacin 100mg DT, cycloserine 125mg mini-capsules, ethambutol 100mg DT, pyrazinamide 150mg DT, ethionamide 125mg DT) • 2019 WHO-recommended all-oral longer regimen for DR-TB treatment • 2020 WHO-recommended bedaquiline-based all-oral shorter regimen for DR-TB treatment • Rifamycin-based short regimen for TB Preventative Treatment	
Definition	Uptake is defined as new medicines/regimens introduced in 26 GDF priority countries for delamanid and 2016 WHO-recommended shorter regimens, 25 for bedaquiline and pediatrics via GDF). 53 GDF priority countries (26 Tier 1 and 27 Tier 2[13]) for child-friendly formulations for DR-TB, 2019 and 2020 WHO recommended regimens for DR-TB treatment and LTBI.	
Rationale for use	KPI focuses on GDF role in providing access to new tools to facilitate expedited introduction (medicines, regimens,) as they become available/recommended.	
How it is measured	Indicator would be tracked separately across the different medicines and regimens as a ratio: # GDF priority countries that have introduced new TB medicines and treatment regimens / # GDF priority countries. GDF will also report the estimated number of treatments supplied to countries for new tools when treatments can be calculated from procurement data. For other tools, volumes supplied will be reported.	
Baseline and Target(s)	**2016 WHO-recommended Shorter Regimen for DR-TB treatment (e.g., kanamycin-based standard shorter regimen)** • **Baseline**: 2015 (0/26) • **Targets Tier 1:** 2016 (25% - 7/26); 2017 (50% - 13/26); 2018 (100% - 26/26) **Child-friendly formulations for DR-TB treatment (e.g., levofloxacin 100mg dispersible tablets [DT], moxifloxacin 100mg DT, cycloserine 125mg mini-capsules, ethambutol 100mg DT, pyrazinamide 150mg DT, ethionamide 125mg DT)** • **Baseline:** 2017 (0/53)	RESULTS **2016 WHO sSTR** Results Tier 1: 2016 - 5/26; 2017-13/26; 2018 -25/26; 2019 -25/26 Results Tier 2: 2016 - 3/27, 2017 - 10/27, 2018-20/27; 2019 -25/27 **Pediatric SLDs (delivered)** Results Tier 1: 2019 (13/26), 2020 (24/26) Results Tier 2: 2019 (8/27), 2020 (23/27)

13 **GDF Tier 1 countries: Afghanistan, Bangladesh, Cambodia, Dem Rep Congo, Ethiopia, India, Indonesia, Kazakhstan, Kenya, Kyrgyzstan, Malawi, Mozambique, Myanmar, Nigeria, Pakistan, Philippines, S Africa, S Sudan, Tajikistan, Tanzania, Uganda, Ukraine, Uzbekistan, Viet Nam, Zambia, Zimbabwe.**
GDF Tier2: Angola, Armenia, Azerbaijan, Belarus, Benin, Burkina Faso, Cameroon, Central African Rep, Chad, Cote d'Ivoire, Eswatini, Georgia, Ghana, Guinea, Haiti, Lesotho, Liberia, Mali, Morocco, Nepal, Niger, Papua New Guinea, Rep Moldova, Rwanda, Senegal, Sierra Leone, Somalia

	• **Targets Tier 1:** 2018 (50% - 13/26); 2019 (75% - 20/26); 2020 (90% 23/26) • **Targets Tier 2:** 2018 (30% - 8/27); 2019 (60% - 16/27); 2020 (90% - 24/27) **2019 WHO-recommended all-oral longer regimen for DR-TB treatment** • **Baseline:** 2018 (0/53) • **Targets Tier 1:** 2019 (50% -13/26); 2020 (75% - 20/26) • **Targets Tier 2:** 2019 (30% - 8/26); 2020 (60% - 16/27) **2020 WHO-recommended bedaquiline-based all-oral shorter regimen for DR-TB treatment** • **Baseline:** 2019 (0/53) • **Targets Tier 1:** 2020 (50% -13/26) • **Targets Tier 2:** 2020 (30% - 8/26) **Rifamycin-based short-course regimens for TB Preventative Treatment (includes 3RH, 3HP, 1HP, 4R in populations not living with HIV)** • **Baseline:** 2019 (0/53) • **Targets Tier 1**: 2020 (20% -5/26) • **Targets Tier 2:** 2020 (12% - 4/27)	**2019 WHO LTR** Results Tier 1: 2019 -21/26; 2020 -26/26 Results Tier 2: 2019 -20/27; 2020 -25/27 **2020 WHO STR** Results Tier 1: 2020 -15/26 Results Tier 2: 2020 -16/27
Data source	• The GDF Order Management System • Country-specific TB medicines quantification files • Missions/Joint Programme Review reports • Regular communications between RTAs/CSOs and country programmes	
Limitations	For new, single-source tools with limited country-eligibility lists for access pricing, the denominator may change with changes in eligibility. GDF has more in–country influence in formulation changes than new drug or regimen introduction as the latter require national guideline and policy changes typically out of the remit of GDF. GDF's visibility on planned WHO guideline changes has increased allowing GDF to prepare countries for changes; however, it remains limited for preparing suppliers based on product lifecycle and development timelines. Treatments procured are back calculated based on procurement data and assumptions. Where treatment regimens cannot be calculated, volumes procured will be reported.	