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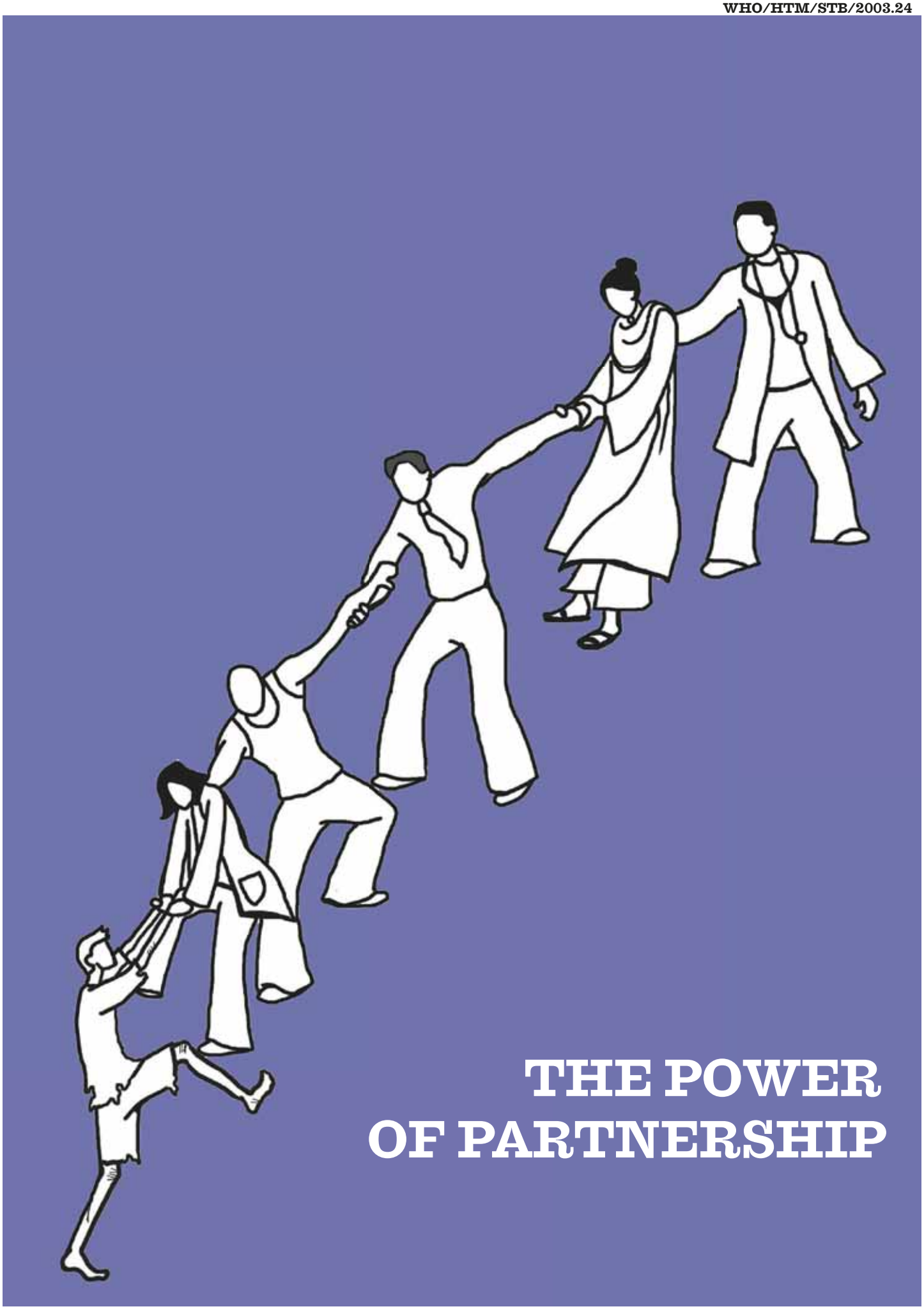
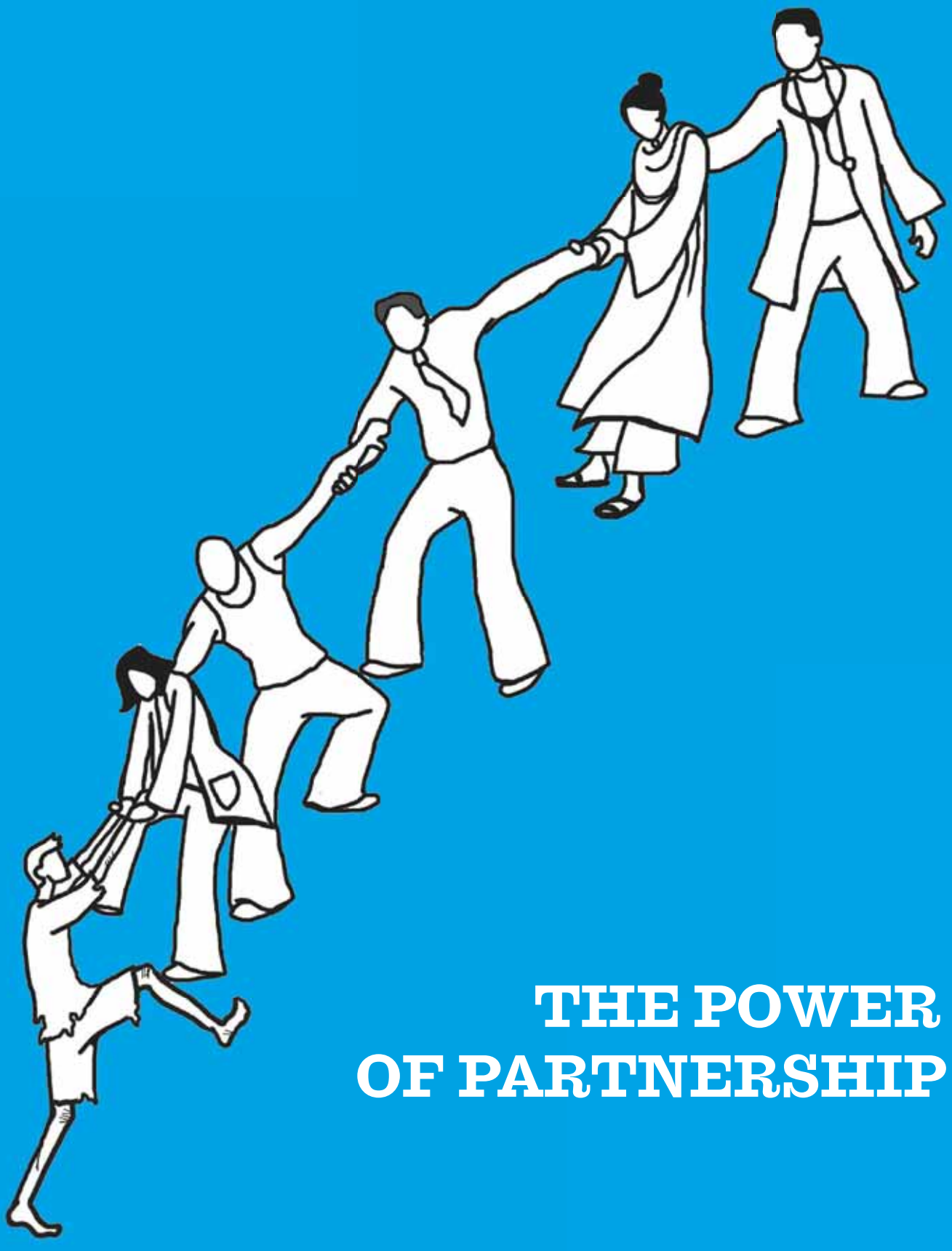


# THE POWER OF PARTNERSHIP

World Health Organization
Geneva, 2003

Global Partnership to Stop TB



# THE POWER OF PARTNERSHIP

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# LIST OF ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| **AIDS** | acquired immunodeficiency syndrome |
| **CCM** | Country Coordinating Mechanism |
| **CDC** | US Centers for Disease Control and Prevention |
| **CIDA** | Canadian International Development Agency |
| **CMH** | Commission on Macroeconomics and Health |
| **COMBI** | communication for behavioural impact |
| **DFID** | Department for International Development (United Kingdom) |
| **DOTS** | internationally recommended strategy for TB control |
| **FHI** | Family Health International |
| **FINNIDA** | Finnish International Development Agency |
| **GFATM** | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| **GTZ** | Deutsche Gesellschaft für Technische Zusammenarbeit |
| **HIV** | human immunodeficiency virus |
| **HLWG** | High-Level Working Group |
| **ICC** | Interagency Coordination Committee |
| **IEC** | information, education and communication |
| **IUATLD** | International Union Against Tuberculosis and Lung Disease |
| **JICA** | Japan International Cooperation Agency |
| **KfW** | Kreditanstalt für Wiederaufbau (German Credit Facility for Reconstruction) |
| **KNCV** | Royal Netherlands Anti-Tuberculosis Association |
| **M&E** | monitoring and evaluation |
| **MCNV** | Medical Committee Netherlands–Vietnam |
| **MDR-TB** | multidrug-resistant tuberculosis |
| **MOF** | Ministry of Finance |
| **MOH** | Ministry of Health |
| **MSF** | Médecins Sans Frontières |
| **NGO** | nongovernmental organization |
| **NICC** | National Interagency Coordination Committee |
| **NORAD** | Norwegian Agency for Development Cooperation |
| **NTLP** | national tuberculosis and leprosy control programme |
| **NTP** | national TB programme |
| **PR** | public relations |
| **SWAp** | sector-wide approach |
| **SWOT** | strengths, weaknesses, opportunities and threats |
| **TB** | tuberculosis |
| **TOR** | terms of reference |
| **TWG** | Thematic Working Group |
| **USAID** | United States Agency for International Development |
| **VCT** | voluntary counselling and testing |
| **WHO** | World Health Organization |

# PREFACE

"Partnership" is powerful. It is a way of thinking, a mindset, an art and a science. It is based on the simple adage that "two heads are better than one" – one on its own is simply not good enough. Partnership invites commitment, eliminates pessimism, and encourages feelings of ownership, responsibility, and pride. It can help people to recognize problems clearly and enable them to find the best solutions. In local situations, it leads to mutual respect among all age groups and all sectors and levels of society.

Partnerships carry great promise. The view that health is solely the responsibility of ministries of health is now outdated. Health has become everybody's business, and partnerships can offer huge advantages to all agencies and philanthropic organizations involved. Partnerships work in quite simple ways: they define the problem, plan strategically with others, explore collective solutions, and implement and evaluate changes. Pitfalls and challenges are common and to be expected, but the outcome of partnership work is not a simple addition of the stakeholders' inputs – it is a synergy of all inputs.

It is not possible or even desirable to make a blueprint appropriate for all countries for building effective partnerships aimed at expanding DOTS. Local conditions will determine the feasibility of any partnership development. These guidelines were developed to define a more dynamic and proactive role for the manager of a national TB programme. They are intended to serve as a roadmap for building functional national partnerships, based on national DOTS expansion plans. They focus on the creation of sustainable partnerships and enduring alliances.

The various chapters of this document tackle fundamental issues such as structuring a national coordinating committee, roles and tasks for the partners, strategies as investment mechanisms, community mobilization and advocacy, and monitoring and evaluation. The benefits and rewards of building strategic partnerships are discussed, as are common concerns and potential problems. Special attention is paid to financing and other collaborative initiatives, such as Country Coordinating Mechanisms for the Global Fund to Fight Aids, Tuberculosis and Malaria (GFATM).

Using these generic guidelines, we hope that national TB programme managers and their colleagues in the health sector will be helped to make the right choices to build partnerships.

**Ger Steenbergen**
**Walid El Ansari**

*Reports of your experiences are very valuable. We welcome your information and comments at the Stop TB Partnership Website (www.stoptb.org).*

# INTRODUCTION — THE GLOBAL CONTEXT

Rapid, massive expansion of DOTS is needed to reach the four million people with TB who do not have access to this effective intervention. Since the *Amsterdam Declaration* in 2000 and the *Washington Commitment* in 2001, the Global Partnership to Stop TB has provided a support framework for national-level partnership coordination. For TB programmes in high-burden countries, a Stop TB Partner is always available to help with delicate negotiations with stakeholders at strategic levels.

## THE GLOBAL TB BURDEN

Growing awareness of the TB epidemic has given rise to grave concerns that this may become a worldwide disaster. In response, *Global Plan to Stop TB* outlines four main objectives in a tight timetable:

- **Expand DOTS coverage.** Meet the global targets adopted by all countries to detect at least 70% of sputum smear-positive cases and to successfully treat 85% of such cases.
- **Adapt DOTS programmes.** Meet the challenge of threats such as HIV/AIDS and multidrug-resistant TB (MDR-TB).
- **Improve TB control strategies.** Develop new drugs, vaccines, diagnostic and policy tools to accelerate TB elimination.
- **Strengthen the Global Partnership to Stop TB.** Mobilize partners at national and international levels by developing structures to coordinate and accelerate effective action, and secure sustainable resources for the control of TB.

If the targets are to be achieved, TB control cannot be imposed from the outside. DOTS expansion means that TB control must become a national issue, sharing the burden with stakeholders beyond just those involved with the traditional national TB programmes (NTPs). However, fundamental responsibility for planning and implementing TB control programmes remains with national governments, through NTPs: DOTS expansion programmes must operate within the routine health services of each country.

Several international organizations are ready to support countries in their DOTS expansion efforts. Under the umbrella of the Global Partnership to Stop TB, a Working Group on DOTS Expansion was formed to coordinate international efforts; it includes technical experts and NTP managers.

## CHANGES IN INTERNATIONAL SUPPORT

The international donor landscape for development cooperation has changed dramatically. New financial donors, including private and philanthropic institutes such as the Bill and Melinda Gates Foundation and the Open Society Institute (Soros Foundation) are showing interest in health issues. In addition, new mechanisms have been established to increase funds for AIDS, TB and malaria through the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).

The more traditional supporters of TB programmes, such as the bilateral governmental donors, have introduced important policy changes aimed at greater local ownership and nationally steered donor coordination.[1] The effect of the new funding mechanisms is less financial aid directed at individual projects and programmes and a greater focus on sector or government budget support, often referred to as basket-funding or sector-wide funding.

Donors and nongovernmental, private, and community-based organizations are becoming major stakeholders in steering social policies and directing funding for health services. Inherent in this new approach is an array of creative "sharing" alliances.

Strategic alliances with like-minded entities (governments or organizations) are the essential mechanisms through which NTP managers will attract far-reaching and sustained support. Stakeholder participation is seen as the key to effective partnership. The involvement of individuals, agencies, and organizations remains the foundation of successful collaborative partnership efforts (El Ansari, 2003).

[1] *This is a development since the 1997 World Bank Report* Assigning aid, *by David Dollar et al., which was followed by the report of the Commission on Macroeconomics and Helath (CMH, 2001).*

## DEFINITIONS OF TERMS

For the purpose of these guidelines, the terms *collaboration*, *partnership*, *coalition*, and *joint* and *interagency working* are used interchangeably. Similarly, the terms *stakeholders* and *partners* are treated as synonymous. More detailed definitions of the various terms used in these guidelines are given here:

**Partnership –** A formal alliance of organizations, groups, and agencies that have come together for a common purposes. Partnerships depend on people.

**Communication –** The sending and receiving of information by the partners and stakeholders to keep one another informed and convey opinions to influence the partnership's actions.

**Coordination –** The combination of activities or inputs to achieve the most effective or harmonious results.

**Cooperation –** Agreement reached between two individuals or organizations whose work together does not progress beyond this level.

**Collaboration –** The development of a model of joint planning, joint implementation, and joint evaluation between individuals or organizations all parties working towards a common purpose. More time is required for collaboration than for cooperation, since activities are shared.

**Networking –** The making and using of contacts between individuals or groups, which are useful to all parties in light of their common purpose.

**Stakeholders –** All individuals and groups with a stake, or interest, in a particular project and a commitment to its success. Stakeholders may not all have equal responsibility for the project but have usually made some financial or resource contribution to it.

**Partners –** All individuals and groups who have actual membership by virtue of joining the partnership. A partner is a stakeholder who is actively involved in partnership activities, on an equal footing with other groups. Partners share central responsibilities for the project.

**Synergy –** The increased effectiveness or greater achievement that results from combined action and collaboration.

*The Power of Partnership* is a guideline for building partnership. It seeks to respond to a growing demand among national, regional, and locally based health care providers for guidance on issues that arise as the national effort is broadened through DOTS expansion. Effective partnerships will help resolve a number of difficulties, including the fragmentary nature of activities and the duplication of initiatives that characterize the situation in many countries.

## CHAPTER ONE

# Building partnerships — principles and priorities

# BUILDING PARTNERSHIPS — PRINCIPLES AND PRIORITIES

## SHARE THE WORK AND THE RESOURCES

The continuing growth of two global threats – HIV/AIDS and multidrug-resistant tuberculosis (MDR-TB) – are adding to the workload for managers of national TB programmes (NTPs) around the world. Proactive initiatives by NTP managers to share the workload are clearly essential. In partnership with others, there is a potential for a greater sustainability. The challenge is to convince institutional leaders, policy makers, and businessmen of the value and benefits of a unique opportunity to improve NTP performance. The principal way of moving forward is not to walk alone but to form strategic links with other organizations at all levels.

## PRINCIPLES

Partnership building is guided by a number of principles:

- **Urgency.** Nearly two million people die every year from a disease for which a cure has long been available at low cost – an unjust situation that requires urgent action.
- **Equity.** The inequities that increase the susceptibility to infection and disease of the most vulnerable groups and reduce their access to good-quality treatment must be reduced.
- **Shared responsibility.** TB is a global public concern and the shared responsibility of everybody.
- **Inclusiveness.** All individuals and organizations that share the vision and values of the partnership are welcomed as members.
- **Consensus.** Partnership strives for consensus on priorities and best practice and for coordinated activities based on the particular strengths of individual partners.
- **Sustainability.** The partnership is committed to sustained action and to strengthening national capacity.
- **Dynamism.** In the face of the constantly evolving epidemic, the fight against TB requires flexibility and continuous innovation.

## PRIORITIES

Adequate resources – financial, structural, and human – are crucial to meeting the new challenges of TB control. These resources are generally scarce and must therefore be used in the most cost-effective way – which is possible only if there is political commitment to realize the goals. Using the right agency for the right job in the right place is the best way to fight TB from different angles.

In summary, three major priorities characterize the successful building of partnerships and programmes in general: money and resources; politics and power; enthusiasm and commitment.

## MONEY AND RESOURCES

Partnerships can be viewed as a means of maximizing benefits. Collaboration is a dynamic process: it will fail if its benefits are not at least equal to its costs. The incentives for working in a partnership are not limited to monetary benefits – they include specific skills derived from the learning experience, the greater collective capacity to respond to the problem, and the increased quality of the solutions.

Being a member of a partnership involves certain costs, not the least of which is the time that must be devoted to the partnership and that is therefore unavailable for other obligations. Other costs include using scarce resources – for transportation and communication, for example – for uncertain outcomes. The possibility of interpersonal conflict may be seen as a further "cost" to be taken into account by partnership members

**IS THE PARTNERSHIP COSTLY?**

- What are the participation costs for a partner, not only in human and financial terms but also in terms of time and effort?
- Are there opportunities for pay-off and benefits to the partner(s), e.g. in leadership of the partnership, wider exposure of the partner's agenda, synergy with other partners' input?
- Are the benefits to the partner at least equal to the costs of the partnership?

## POLITICS AND POWER

Not all partners are the same – they may have widely different backgrounds. As the power differences between parties in a relationship increase, formal terms of collaboration may be required, in which each partner on its own must be individually recognized. In the early stages, partners may not represent a single cohesive group but are rather a mixture of groups, interests, and resources. Some have more power and status than others. Competition and even conflict between members is likely to happen in any partnership. This must be skilfully managed. Wide discrepancies in terms of power are not conducive to interagency working and are likely to result in distracting influences on emerging policies. Power can take many forms: access to data and information (information power), resources and funds (economic power), and the competencies, capacities, and proficiencies of the stakeholders (technical power). Maintaining a power equilibrium is conducive to feelings of "togetherness" (El Ansari, Phillips & Zwi, 2002).

## ENTHUSIASM AND COMMITMENT

Notwithstanding the importance of commitment, overenthusiasm – partners wanting to move at greater speed than the programme can handle – may potentially derail parts of the programme. As all components of the programme are interrelated, smooth coordination is essential. If partners move independently with their own resources and assets, the NTP manager may well lose control over the programme activities. A well-managed national interagency coordination committee (NICC) should be able to curb this tendency. However, this demands considerable tact and sensitivity on the part of the NTP manager – it would be equally harmful if an overenthusiastic partner felt unappreciated. Unless carefully managed, even well-intentioned overenthusiasm can quickly backfire and take a negative direction.



### ARE THE PARTNERS OVERENTHUSIASTIC?

- Are there new stakeholders, who wish to join the "bandwagon" with enthusiasm as their only contribution? They may push too fast for quick results without taking into account the operational difficulties of a health project.
- Do potential partners frequently want to quickly "get their teeth" into a project without thorough, appropriate planning?
- Does the overenthusiasm of some partners lead to confusion, with too many wanting "hands-on" involvement?
- Is the timing of the enthusiasm among the partners in line with the funding and the implementation of activities?
- Do the initial bursts of enthusiasm to implement partnership programmes soon wither, to be replaced by feelings of frustration? Such frustrations may cause partners to consider the partnership as an institutional manipulation.
- Is there a healthy fit between the enthusiasm of the partners and their expectations? Unfulfilled expectations may obstruct commitment, stall the progress of collaborative efforts and cause disconnection.

In establishing a Stop TB Partnership it is useful to bear in mind the range of issues involved in the collaborative work. It is absolutely critical to manage the political environment to support the partnership. However, attention must also focus on the alignment of policies of other sectors in order to be successful. External assistance should be requested for various collective tasks only if there are vital gaps that cannot be fulfilled by national resources. Also inviting external agencies to participate in a national response will enhance the chances of successful resource mobilization.

**PARTNERSHIPS ARE GRADUAL AND INCREMENTAL PROCESSES THAT REQUIRE TIME TO GAIN PACE, BUILD MOMENTUM, AND BEAR FRUIT.**

# CHAPTER TWO

## Building national partnerships to stop TB

# THE NATIONAL DOTS EXPANSION PLAN

The starting point for building Stop TB partnerships is to reach agreement on the national DOTS expansion plan. The plan is the primary structure for establishing the goals and objectives that govern the actions of the NTP in developing partnerships. Forming a committee composed of existing agencies and organizations is a good first step for hearing opinions, drafting the DOTS expansion plan, and laying the foundations for the national partnership to stop TB. An organization that wishes to join a partnership effort must first consider two important factors – its own interest or stake in the outcome, and its perceived interdependence with other groups. Unless these factors are taken into consideration, the organization will not be in a position to assess other important stakeholders as its future collaborators or to evaluate the available resources needed for such collaboration.

The national DOTS expansion plan describes the objectives, products, activities and budget for controlling TB in a country. For strategic reasons, the plan should cover a period of 3–5 years if it is to be successful; it should include a situational analysis and describe what further action will be needed over time. The plan must be carefully drafted, guided always by a sound sense of proportion and feasibility. It is crucial that the plan be formulated according to local conditions, making the best use of local assets and including all potential partners. A solid TB control programme with high patient cure-rates can be an excellent basis for expansion, but expanding a programme with poor performance will result only in greater difficulties. Priority must therefore be given to programmes that have performed well. Once good-quality procedures and practices are in place, the programme can start expanding its work, involving other partners and/or programmes and by adopting new initiatives.

Once agreement is reached on the principles and priorities of the national DOTS expansion plan, the foundations for the actual partnership are laid. The plan outlines the necessary activities and the related specific needs and resource gaps – and thus provides clear indication of the additional support that is required. Thus, the action plan for the building of a partnership has clear targets against verifiable indicators, and details the tasks that are the responsibility of each of the collaborating agencies.

**CHARACTERISTICS OF A GOOD ACTION PLAN FOR INVOLVING OTHERS IN DOTS EXPANSION**

| | |
|---|---|
| *Specific* | Activities are described in clear terms so that everyone understands what is included and what is not. Roles, duties, and responsibilities are clearly defined. |
| *Measurable* | The products must be easily measurable against targets, to ensure that the right progress is being achieved. This has implications for the indicators that are formulated, the intermediate outcomes that will be measured, and the short- and long-term impact that will be assessed. |
| *Appropriate* | Only those activities that are appropriate to the local conditions and challenges are included. This has implications for the partnership's culture, values, standards, ethics, and diverse "ways of doing business". |
| *Relevant* | Only those activities that can contribute to the achievement of the targets are undertaken. This has implications for the range of stakeholder priorities, activities, budgets, and planning. |
| *Time frame* | All activities are planned in specific time frames. This has implications both for the gradual and incremental fostering of partnership, with partners proceeding at their own pace, and for the funding cycles of donor bodies or other financial assistance foundations. |

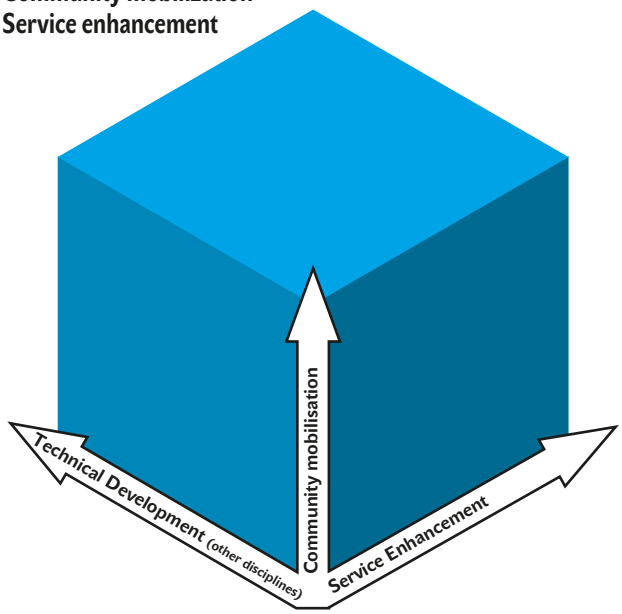
# EXPANSION AND NATIONAL PARTNERSHIP



Many countries were neither geared nor equipped to meet the growing demands of the TB burden, particularly when overall resources for health and health services were becoming increasingly scarce. DOTS expansion calls for more partners to join the fight against TB.

Expanding the NTP in accordance with the principles of the national DOTS expansion plan requires the building of strategic links with others, and means building in three "dimensions":

- **Technical development**
- **Community mobilization**
- **Service enhancement**




To ensure that the expanded response is a solid construction, all three dimensions must be developed in parallel. If one dimension grows without the simultaneous growth of the others, the result will be an unstable and inappropriate structure.

*A unidimensional development that lacks support and input from the other two dimensions is likely to collapse.*

In simple terms, the three dimensions translate into – more resources, more people, and new expertise. For an NTP, all three levels are intrinsically linked and equally important. For example, focusing only on the mobilization of financial resources does not add new skills or increase community involvement. Similarly, focusing on traditional technical input alone does not automatically mean more money or new people. All three approaches therefore need to be strengthened with relevant and appropriate partners for each dimension.

The development of each dimension can be summarized as follows:

## DIMENSION 1: TECHNICAL DEVELOPMENT

The increasing burden of TB clearly cannot be addressed by the NTP alone. While the NTP has the technical know-how for TB control, it may not have relevant skills beyond that. This highlights two critical factors – the range of multidisciplinary skills that need to be represented or actively developed within the partnership, and the need for intersectoral efforts to build a more coordinated and comprehensive response (El Ansari & Phillips, 2001a). A comprehensive response extends beyond the formal health sector to include other non-health government sectors such as housing, agriculture, transport, and labour. Without joint planning, and perhaps joint legislation, duplication of efforts is common and results in wastage of resources. Enriching the NTP with approaches and resources that have been developed by others can mean a significant upgrading of the quality of DOTS expansion.

The following few examples illustrate how certain other disciplines are important to TB:

- TB is a disease of poverty and is closely related to all development issues.
- The economic impact, budgeting, and financial accountability of DOTS expansion require the expertise and involvement of the financial sector.
- Communication, advocacy, and social mobilization initiatives to Stop TB need marketing, communication, and public relations (PR) experts.

**BUILDING BLOCKS FOR THE GROWTH OF THE TECHNICAL DEVELOPMENT DIMENSION INCLUDE:**

- Good public health practices from other programmes. Issues with wider relevance for the health sector should be included in the interventions that apply to TB (advocacy, innovation in public–private mix, patient (client) involvement).
- Operational research and development of new tools. For example, the success of the Pro-Test TB/HIV intervention started in sub-Saharan African countries as an operational research activity has led to its being introduced as a routine feature of TB and HIV collaboration. It aims to reach potential new cases of TB among HIV-positive individuals who attend voluntary counselling and testing (VCT) centres.
- Good financing, marketing, and advocacy practices from the corporate and private sector. For example, South Africa contracted a local commercial PR company for World TB Day 2003 and the World Cup Cricket in order to raise greater awareness of TB. Using advertising professionals is likely to achieve good, high-quality exposure for the TB campaign that appeals to the general public.

## DIMENSION 2:
## COMMUNITY MOBILIZATION:

Detecting more cases means involving communities in the fight against TB. In many countries and communities, civil-society organizations are emerging as critical but constructive counterparts of governments. Communities represent people's needs and thus both provide a direct link for informing people about TB, and support advocacy for DOTS. Effective programme implementation that is well rooted in the community requires the analyses of community mobilization and organization. It encourages people to take control of their lives in the context of their social and political environment. Through collective action and consistent support, the capacity of people can be strengthened and any vulnerability – marginalization, stigma, poverty, powerlessness, infirmity, or disease – is reduced (El Ansari & Phillips, 2001b).

Working together has to be founded on communication and nurturing relationships. Professional knowledge needs to be fused with the practical wisdom, experience, and service of the community. Hence partnerships with community members need to create open communication, connect science with service, share skills and information. Communities must not be viewed solely as sources for identifying needs and deficiencies, while their value and capacities are overlooked.

### IS THE PARTNERSHIP "COMMUNITY-SENSITIVE"?

- Participation is about moving away from a "them and us" mentality towards benefit for all parties.
- Is lay knowledge welcomed by the partnership in striving to understand the determinants of, and potential solutions to, the problem?
- Are ownership and control of the partnership shared equally between the stakeholders, including community representatives?
- Is there an appreciation of skill-mix in the partnership, with each partner valuing the contributions of others at the core of the collaborative effort?
- Is input from front-line workers and community representatives who serve high-risk populations fully appreciated by members of the partnership?
- Are there any signs in the partnership that lay perceptions are given less value than technical perspectives ("credibility hierarchy")?

## DIMENSION 3:
## SERVICE ENHANCEMENT:

If the availability of DOTS services remains limited to selected "DOTS centres", it is unlikely that the whole population will benefit. The delivery of DOTS services must expand to include access through nongovernmental services, such as private practitioners, local traditional healers, and workplace/corporate sector services. Expansion of services in this way will more appropriately address individual and family lifestyles and particular communities. The perspective of the employer may be considered as an example. While it is TB patients who are directly affected, employers are also subject to various economic repercussions – sickness and terminal benefits, indirect costs of sick leave, etc. Using DOTS, employees can be treated on an outpatient basis and return to work sooner.



### BUILDING BLOCKS FOR THE GROWTH OF THE SERVICE ENHANCEMENT DIMENSION INCLUDE:

- Special DOTS centres – clinics that deal almost exclusively with TB/lung health and the provision of DOTS.
- All public health facilities able to provide DOTS services – general public health clinics provide DOTS as part of their routine services. This requires additional training for general health workers and close supervision by NTP experts to ensure that DOTS is carried out properly.
- Involvement of private and corporate health providers in DOTS delivery – inclusion of private practitioners and other nongovernmental (e.g. industrial) health service providers makes DOTS accessible to more people with symptoms. Government health workers and the NTP frequently have only limited influence on these providers, most of whom will require training before they can be relied on.

### ARE THE PARTNERS EXPERIENCED IN PARTNERSHIP WORKING FOR SERVICE ENHANCEMENT?

- How are the members' educational competencies used in dividing the work of the partnership?
- Among the membership are there individuals with partnership-fostering expertise?
- Do members have the strategic and management capacities that are essential for working together?
- Are team-building abilities given enough attention?
- Are partnership members supported with the community involvement skills needed to achieve real commitment?
- Partnerships are for change – are the partners equipped to function as agents of change?

## SUMMARY:

**A good fit between the nature of the partnership, the administrative tasks, and the abilities of partnership members is crucial. The members of a partnership are its primary asset, with each contributing a different set of resources and skills to the collective action. The competence and performance of each member are positively related to the coordination of the participating organizations. Among the skills necessary for successful collaboration are conflict management, sharing power, appreciating differences, and resource retrieval. Resource retrieval is defined as choosing and using the available material and resources needed for any given task. It also includes learning how to turn resistance to change into a positive force, developing the ability to recognize the contributions of all participants, and knowing how to evaluate and provide feedback.**

# CREATING PARTNERSHIPS
## Analytical framework



| BUILDING BLOCKS (What elements do we wish to expand?) | GOALS (What do we wish to achieve?) | EXISTING CAPACITY (Where are we now?) | NEW CAPACITY REQUIRED (What do we need in order to complement existing capacity?) | |
|---|---|---|---|---|
| **DIMENSION 1 – TECHNICAL DEVELOPMENT** | | | | |
| Good public (health) practices from other programmes | To broaden the types of interventions to achieve state-of-the-art practices | Only TB control expertise | Experience with best practices from other programmes that have potential value for DOTS expansion | |
| Operational research and development of new tools | To achieve evidence-based management and stay abreast of new developments | Monitoring and evaluation of control efforts | Tools and evidence-based answers to questions .<br>To reach more people, to improve access to care, to simplify the application of DOTS expansion elements (diagnosis, treatment) | |
| Good financing, marketing, and advocacy practices from the corporate and private sectors | Sustainable and reliable funding from a wide variety of sources to reduce the risk of depending only on a limited number of sources | Traditional sources of funding and financial control<br>Ad hoc marketing by the traditional agencies, as well as piecemeal advocacy | To establish international credibility for transparent financial and resource management<br>To approach new and nongovernmental sources for funding<br>Presentation of TB and DOTS information that appeals to potential investors | |
| **DIMENSION 2 – COMMUNITY MOBILIZATION** | | | | |
| Involve immediate relatives and family of patients | To ensure treatment compliance | Occasional/ opportunistic use of family members | To address patient behaviour and family roles and determine responsibilities in managing health problems | |
| Involve communities in DOTS | Communities to actively address the TB problem | Small pilot project | New skills for collaborative interaction and development of interface with health care providers | |
| Empower communities to change from passive recipients to active participants in the fight against TB | Communities are well informed and respected counterparts | Few/occasional activities | To empower communities to speak out for action on health<br>Skills to guide constructive community change | |
| **DIMENSION 3 – SERVICE ENHANCEMENT** | | | | |
| Special DOTS centres | Lung health and other clinics to provide DOTS | NTP-supervised clinics | To improve operational deficiencies in the NTP<br>Engage other special clinics | |
| Involve all public health facilities in the provision of DOTS | Public health facilities are able to provide DOTS services | Liaison with general health services | Joint planning (legislation), and implementation to ensure that DOTS is included in the basic package of health services at the lowest level | |
| Involvement of private and corporate health providers to deliver DOTS | Health service providers offer DOTS | Limited experience with nongovernmental partners | Engage private practitioners and other health professionals outside the government<br>To overcome a sense of competition and stubbornness | |

| | NEW PARTNERS<br>(With whom are we going to achieve our goals?) | SUGGESTIONS<br>(Examples of existing possibilities where relevant + new capacity and pooling expertise and resources) |
|---|---|---|
| | | |
| | Poverty alleviation partners<br>Community development partners<br>Social and religious services<br>Other health programmes (HIV, Expanded Programme on Immunization, essential drugs) | • Commitment of lay community representatives in partnership activities<br>• Secondment of individuals from participating agencies to provide the day-to-day running of partnership activities<br>• DOTS continuing education for key health workers<br>• Professional strategy for national communication and dissemination services |
| | Academia, medical schools, social researchers<br>Epidemiological and demographic experts<br>Experts for clinical trials and pilot studies, laboratory experts | • Research and implementation work hand in hand: research can reveal new tools and approaches that benefit the implementation. Conversely, practice can raise important and relevant research questions<br>• Capitalizing on visits of technical experts to contribute to capacity-building for the partnership<br>• Participation in operational and activity research is a capacity-building process for front-line workers |
| | Private financial auditor agencies<br>PR/advertising /marketing<br>Corporate management | • Expansion and alignment of fragmented financing across budget lines, settings, providers, managers, and administrations<br>• Incentives for cost-effective advocacy and prevention strategies<br>• Promote certain kinds of expenditure of public funds on TB partnerships |
| | | |
| | Religious organizations and civic groups<br>Tribal/cultural agencies<br>Community-based credit unions<br>Women's groups | • Quality information for adherence to DOTS<br>• Self-monitoring support, self-management skills<br>• Quality interaction with sensitivity for patient-specific issues<br>• Joint educational and skill-building workshops |
| | Sports and social clubs<br>Parent/teacher associations | • Effective strategies for case-finding and holding<br>• Promoting social coherence, positive peer pressure and sharing in learning about health issues |
| | Patient organizations<br>Market associations<br>Political organizations<br>Labour unions | • Constructive interaction between communities and providers on an equal basis (jointly searching for solutions to felt needs)<br>• Integrating community resources into the fight against TB<br>• Community commitment in the politics of policy-making |
| | | |
| | Prisons, police, military, industrial, and university health services | • DOTS services expand as they are include in other governmental and parastatal special clinics |
| | District health management teams<br>Provincial health management<br>Patient organizations | • DOTS is a priority element in the district health plan, including the allocation of local resources<br>• DOTS tools and expertise for general health workers and volunteers<br>• Continuing education includes TB and DOTS<br>• Effective collaborations with clients/patients |
| | Private practitioners<br>Medical associations<br>Non-profit health care providers<br>Corporate/industrial sectors | • Inter-professional and intersectoral links and relationships with a range of professional organizations, businesses<br>• Strong advocacy skills and political connections<br>• Adapting values in order to accept new goals |

# POTENTIAL COUNTRY LEVEL PARTNERS



Based on the needs of the DOTS expansion plan, the first task of the NTP is to draft a strategy for developing partnerships, with criteria for the level of involvement and contribution of new partners.

## ALIGNING THE PARTNERS

To establish a structure and align all partners for an effective response, it is important that a transparent assessment be carried out against the background of DOTS. Exploring options for working together and building relationships requires that this be done in a spirit of mutual respect, commitment to a common task, and sensitivity to the needs of the various partners. At times mutual trust and credibility need to be developed before partners can be expected to work together. In order to develop a common outlook it is useful for the stakeholders to explore their expectations of tackling the ambitious task together.

## STAKEHOLDERS ANALYSIS

Building a consortium of institutions with different cultures for a joint effort can be an arduous task. The NTP needs to map out the organizations that are already known and the potential partners that are still missing. Each partner will have different criteria of effectiveness because it has a different interest in the partnership. Analysing and attracting strong stakeholder assets to the programme, along with commitment, are major elements in the success of partnership efforts.

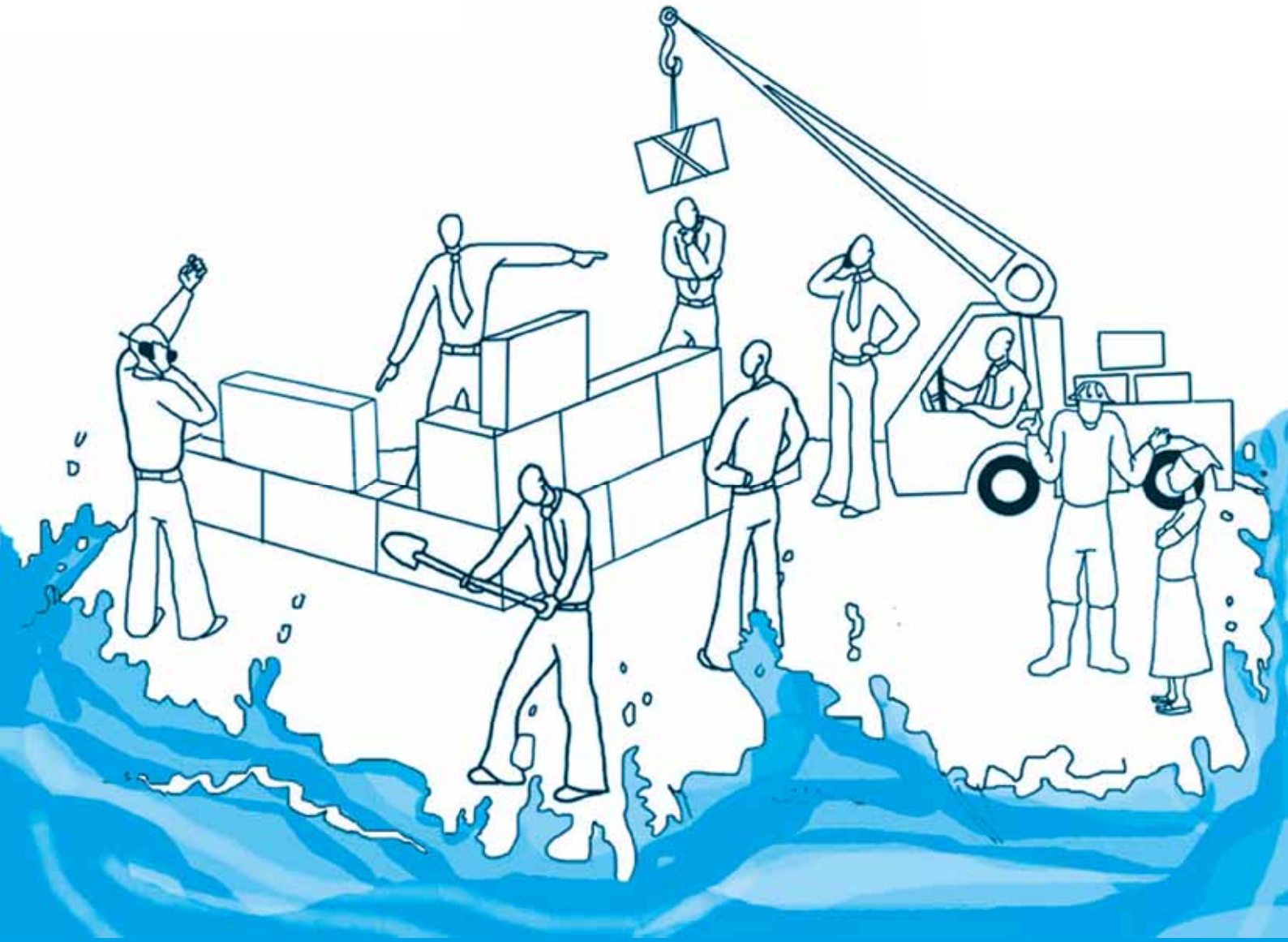
Stakeholders analysis is crucial. It will help in identifying potential partners and assessing their relevance. Questions are asked about the position, interest, influence, interrelations, networks, and other characteristics of the stakeholders, with reference to their past and present positions as well as to their future potential. As government determines the overall policies and outlines the framework of cooperation, government representatives are the initiators of the partnership and accept ownership and responsibility of the process.

Once overall stewardship by the government has been established, understanding each partner's contribution is the next important step. As part of the process of the partners getting to know each other better, their comparative strengths and weaknesses should be analysed. The findings must be shared openly in an effort to achieve consensus on the available assets and weaknesses. This can be a very sensitive undertaking – partners may not all want this degree of exposure in the early stages of a partnership. High-quality support from an external facilitator during these SWOT (Strengths, Weaknesses, Opportunities, and Threats) meetings is vital. With consensus, the value of each partner can be better established and used as the basis for DOTS expansion. A statement of the partners' expectations from the partnership should be recorded to facilitate later evaluation of results.

## SUMMARY

Knowing your partners is crucial! Based on the common goals, and guided by the priorities and gaps in the DOTS expansion plan, the NTP is responsible for assessing and grading these partners according to their value in tackling priority issues. Examples are given in the table below:

| TYPE OF ORGANIZATION | PRIME INTEREST | VALUE FOR DOTS EXPANSION |
|---|---|---|
| Human rights groups | Human rights | Awareness and legal expertise |
| Patient associations | Patients' rights | Advocacy |
| TB and lung associations | TB awareness | Advocacy and network |
| Sports associations | Sport promotion | Community involvement |
| Service clubs | Community service | Support |
| Business/corporate sectors | Benefits and profits | Service delivery |
| Professional associations | Education and standards | Management and training |
| Private practitioners, hospitals, prisons, military | Health care and medical service | Capacity building and service delivery |
| Ministry of Finance | Public finances | Financial resources and expertise |
| Journalists/Media houses | Public information | Public awareness and commitment |
| Education sector | Education | Knowledge of TB |



# CHAPTER THREE

## Partnerships — possibilities and pitfalls

**Some partners may not see the partnership as a priority, and it would be wrong to assume that people and institutions are universally ready and waiting to be engaged in the process. Participation entails accepting responsibility for any decision made, and the complexity of each partner – which does not necessarily represent a homogenous group – needs to be recognized. Potential partners may be reluctant to spend their limited time and resources on partnership development activities. While the benefits of the partnership are substantial, it is important to remain realistic and to recognize the likely difficulties.**

## POSSIBILITIES

A well-managed partnership can tackle much greater problems than an NTP run on traditional lines and can provide expertise that is not otherwise readily available. The active involvement of more partners can help share the burden of the control efforts.

The work of organizations engaged in strategic partnerships will benefit from faster development and implementation. Partnerships also result in improved networking, information sharing, and access to resources – as well as enjoyment of the work, personal recognition, and skill enhancement. The potential for discovering novel solutions, based on broad and comprehensive analysis, is much greater, while the costs associated with other ways of solving the problem are reduced. Nevertheless, perception of the benefits of partnership will reflect the values and cultures of the individual stakeholders.

### IS THE PARTNERSHIP BENEFICIAL TO THE PARTNERS?

- How will the "royalties" and accomplishments of the partnership be shared?
- What are the individual benefits derived from participating?
- Are there benefits for a stakeholder's constituency in being part of the partnership?
- What are the short- and long-term benefits of a collaborative programme?
- Do the benefits include system changes and reforms?
- How do the benefits compare with the costs?

## PITFALLS

Working with partners also means involving non-traditional partners, which may introduce new perspectives. In most cases this will enrich the overall programme, but the development of new relationships may also hold potential hazards. Vigilance on the part of the NTP manager is therefore essential if the pitfalls that may be encountered at any stage during the development of a partnership are to be recognized and avoided. Potential challenges include the following:

- passive and dominant partners ,
- unrepresented or under-represented stakeholders,
- inflexible and insensitive partners,
- unreliable partners,
- human factors.

## PASSIVE AND DOMINANT PARTNERS

There are partners who wish to be seen as being involved yet use the partnership as a political tool or for self-serving publicity while contributing nothing. This type of "free-riding" passive partner should be avoided – it will confound the dynamics of the partnership and have little, if any, positive impact. Initially, it may be worth discovering whether and to what extent such "sleeping partners" can be "woken up" to active and constructive involvement. However, if this cannot be achieved, it may be necessary to ignore such partners and even try to eject them from the partnership if this can be done without further detriment.



**ARE THE PARTNERS ACTIVE?**

- Do the partners recruit new members to the partnership?
- Do they serve as spokespersons for the partnership?
- Do they work to implement educational/cultural activities or events sponsored by the partnership (other than meetings)?
- Do they serve as representatives of the partnership to other groups?
- Do they serve on partnership committees and task forces?
- Do they contribute (in terms of time, effort, and financing) to the achievement of operational objectives?

Conversely, dominant partners can also be disruptive. Because they provide the bulk of the (financial) support, they may feel that they more or less "own" the programme. They can become overbearing during NICC meetings, preventing decision-making from being a smooth process that involves all. Consultations *must* be two-way processes. It is essential for the partnership to be based on mutual dependence and not become unbalanced, with one dominant party using the other stakeholders and groups to serve its own agenda and policies.

It is the NTP manager's role to handle group dynamics successfully, and managing dominant partners requires special sensitivity and skills. Sometimes a direct, private approach may work. It is worth finding out which agency the dominant partner considers to be a "peer agency". Approaching a sympathetic partner on the NTP's behalf to discuss the dominant attitude and behaviour of another can be a diplomatic way of addressing the issue.

**ARE THE PARTNERS DOMINANT?**

- Are there particular stakeholders who have a lot of influence in the major decisions?
- Are decisions made only by a small group of leaders?
- Are some partners too outspoken?
- Is it easy for any partner to communicate ideas to the leadership?
- Do partners feel that they have sufficient opportunity to participate?
- Is there wide participation and consensus in decision-making by the different partners?

## UNDER-REPRESENTED OR UNREPRESENTED STAKEHOLDERS

Partnership composition and representation are critical factors for healthy collaboration. Collaborative efforts require that all constituents be represented in the partnership and that all voices be heard. Project sustainability is also affected by the composition of the partnership. Changes in the internal structure of the various stakeholders may occur over time and may result in a high turnover of representatives. It is useful to classify representation into formal or informal, which will affect representatives' authority to take binding decisions on behalf of their organizations. A strong representative membership base represents strength to the partnership.

**ARE ALL THE STAKEHOLDERS REPRESENTED?**

- Are communities and their factions well represented?
- How are representatives identified, selected, and recruited?
- What is the relationship between representatives and their constituents?
- Are the stakeholder representatives the appointed leaders or the natural leaders?
- Is participation limited by any inclusion criteria?
- What is the nature of the relationship with staff of community organizations or with grass-roots support?
- Are the poorer and sicker members of the community represented in the partnership?
- Is the community perspective presented and likely to be heard?

## INFLEXIBLE AND INSENSITIVE PARTNERS

Partners that believe that they, exclusively, have the wisdom and vision for the programme are likely to destabilize the partnership. They may pose a real threat to the NTP manager and can become abrasive towards other partners whose approach is more modest. Here again, the NTP manager must provide programme leadership in a way that is acceptable to all – for example, by diplomatically including the favourite issues of an inflexible partner, thus satisfying that partner while maintaining peace and order in the overall programme management. On the other hand, inflexibility and insensitivity must not be rewarded by allowing freedoms that are not in line with those of others. The principle of give and take is a key negotiating skill for the NTP manager.

**ARE THE PARTNERS FLEXIBLE AND SENSITIVE?**

- Are there major differences in partners' philosophies?
- Is there coordination in goal-setting and activities among the partners?
- Is there competition between stakeholders in the service areas or populations that are being served?
- Is there an assumption of leadership by a lead partner? Are particular agencies sending out messages of "ownership" of the partnership?
- Are leadership roles given to activists, whether or not they possess leadership skills?
- Is there a perception that the education of health professionals prepares them to assume leadership roles?
- Is power equally distributed within the partnership?
- Are self-interests or power disparities evident from strained interpersonal relationships, nepotism, centralization of authority, or non-devolution of responsibilities?

## UNRELIABLE PARTNERS

Partners who promise much but fall short of the expectations raised need to be held accountable. The failure of partners to adhere to the conclusions and decisions of the NICC has a negative effect on the cohesion between the partners. Looking together for solutions outside the NICC meeting, perhaps by involving other partners, will reduce the potential embarrassment and may eventually strengthen the partnership bonds. The NTP manager must know exactly what services a partner is supposed to deliver and when. It is wise not to wait until the NICC meeting to remind a partner, but take the initiative for a consultation. Discussing this in the NICC meeting would simply increase embarrassment for all concerned.

**ARE PARTNERS RELIABLE?**

- Do the partners deliver what they promise within the agreed time frame?
- A perception of unreliability may be caused by misunderstandings and/or poor communication, leading to false expectations. An NTP manager can largely prevent this by being aware of the following:
  - Do the partners communicate? Are there established communication patterns and does information reach the entire membership? Is anyone excluded?
  - Are relationships and interactions characterized by tolerance and agreement? Are there established ways for the partnership's decision-making, problem-solving, and conflict-resolution processes?
  - Do the partners have a sense of ownership of the partnership?
  - Are the partners satisfied with how the partnership operates and consider it to be worthwhile? Are there groups who are not satisfied with what the partnership has accomplished or who feel that the work accomplished has not come up to their expectations?
  - Do the partners feel and reap the benefits of the partnership (e.g. in terms of acquiring skills, knowing more agencies, reaching target beneficiaries)? Do benefits outweigh the costs (in terms of time, effort, in-kind resources)?

## HUMAN FACTORS

Effective partnerships depend on a range of human qualities such as open-mindedness, negotiating skills, tolerance, patience, and perseverance. However, essential though these qualities are, they are not sufficient to guarantee a real partnership: stakeholders should establish good relationships with each other. Also they must and consequently instil in their own organizations the essential sensitivity and respect for other organizations. Since many partners lack the necessary negotiating skills, the presence of a facilitator can be very useful in bringing them together with a focus on partners' motivation. The champions, coordinators, and facilitators of collaborative efforts can thus be identified. They can be strategically placed with respect to their comparative advantages, to play pivotal roles in the advancement of the alliance. With partners located in their proper niches, the working conditions of a partnership are enhanced. Accordingly, the characteristics, styles, and attitudes of the partnerships' central figures, the convenors, are critical in allocating to each partner an appropriate function and role.

# CHAPTER FOUR

## External assistance to national partnerships

# INTRODUCTION
## Summary of issues

Most countries lack sufficient local resources to implement DOTS expansion plans. These missing resources are mostly financial, but there is a shortage of adequately trained and motivated staff. Many programmes therefore require external support in order to implement the DOTS strategy, and in this respect NTPs are no different from any other programme or sector. Sometimes there is fierce competition among programmes for donor support.

While external assistance may help countries to reach targets within the shortest possible time, there can be undesirable side-effects. For instance, individual "demonstration" projects need to ensure that they can grow without depending fully on an external donor. Starting and maintaining a good relationship with external agencies requires special skills to take advantage of the opportunities and to limit any potential for negative interference. An important element in evaluating the assistance to countries is observing how well the external agencies balance their assistance with the ability of these countries to make proper decisions. In addition to financial support, donors sometimes provide significant technical support, programme leadership, and dissemination of information about the programme to the media and public policy-makers.

Success in partnership work can be measured in terms of longevity – that is, a lasting effort is more likely to have a longer-term impact. It is important to ask "What are we trying to sustain?" Not all outcomes are sustainable, and a degree of realism, as well as acceptance of compromise, is therefore essential. The sustainability equation involves a mixture of organizational, structural, financial, operational, and human factors, as well as the barriers that may be encountered (El Ansari and Phillips, 2001c).



Partnerships must fit into broader systems. External resources should be used principally to provide a "safety net" and should be available only for a specific period of time. External inputs and skills should add to, rather than replace, local ones. The focus must remain on empowering national programmes to acquire and sustain effective control of their DOTS expansion efforts.

# TECHNICAL COLLABORATION

Technical and financial assistance are two different types of external support that need different approaches. Tuberculosis control, seen as part of the whole health care system, uses the available general health facilities and staff but at the same time suffers from the deficiencies of that health care system. The effect of any DOTS strategy will therefore depend greatly on the quality and coverage of the system. Fortunately, no country and no NTP operates in isolation – international guidelines are available to assist countries to determine their own plans, following the principles of the DOTS strategy. An international expert, with wide experience in TB control from other countries, can do much to help a country implement the DOTS strategy. Such technical support can help in avoiding mistakes. An international expert or adviser can bring in available, tested packages for DOTS components that can be adapted to the local conditions with much less work than starting from scratch. During the implementation period, an international expert can also help in overcoming unexpected obstacles. Finally, some donor agencies consider the input of external experts as a form of quality assurance and an insurance for their investments.

While the benefits of technical assistance are clear, NTP managers should carefully appraise all advice from abroad in terms of long-term feasibility. Appropriate interventions in country A may be counterproductive in country B. It is the responsibility of the NTP management to make the final decision on appropriate action. The best technical assistance is therefore the result of continuing dialogue between the country concerned and the international experts or advisers.

**QUESTIONS TO BE RAISED WHEN APPRAISING INNOVATIVE ADVICE IN A TECHNICAL COLLABORATION**

- *Will the advice produce results that will alleviate the problem?* Is there evidence that the advice given has worked in other similar settings?
- *Can it work in the local setting?* Is it applicable in this context? Is there evidence that it could work here?
- *Can the patients, staff, and the politicians accept it?* Is the advice likely to be acceptable to the public and politically viable?
- *Is it affordable in the long term?* What are the costs and what is the evidence on the cost-effectiveness of the advised activities? Are they likely to be sustainable through local or national support?
- *Can it make the NTP more independent?* Are there clear or likely benefits? Is the advice going to contribute to saving or generating resources, and contribute to better control in the future?
- *Can it improve our overall performance and international reputation?* Is it efficient, will it improve the productivity of the programme, and will it contribute to a better national and international image?

# INVESTMENT STRATEGIES (Managing financial resources)



Most governments of developing countries with limited national resources become dependent on (donor) support of the health sector and are therefore vulnerable. When the need for additional funds is high, the line between a sympathetic, helpful donor and a micro-managing financier can become extremely thin: some donors may insist on conditions that constrain the recipient country's freedom to determine its own policies. Adhering to the established DOTS expansion strategy yet not upsetting a generous (potential) donor requires special negotiation skills and a support network of contacts that can assist in maintaining such a donor's interest in DOTS. A credible and united response from the stakeholders will have a stronger impact on donors. Similarly, donors are more likely to support a sustainable, multi-organization partnership effort than a one-off single-department initiative. Attracting investments means building bridges.

## EARMARKED INVESTMENTS FOR DOTS EXPANSION

In most countries, the greater proportion of investments for programmes such as TB control comes from the national budget. There is fierce competition for these resources both between sectors and between programmes within sectors. Allocation of resources from the national budget is actively advocated by NTP managers, which requires outlining the need for TB control as part of the national health budget as well as strategic negotiation. The relationship between the TB burden and the loss of national productivity needs to be made explicit, and the need for solutions coordinated by other sectors must be emphasized. Over-reliance on international funding will not help in the long run. Other types of support are needed for the continuity of programmes in terms of integration into public policy. International funding alone cannot ensure this – direct public policy support is required. For example, focusing exclusively on donor funding and thus neglecting the potential to raise the budget-allocation for DOTS expansion is not conducive to future sustainability. Mobilizing national resources for TB can be done by putting TB firmly on the national agenda and by creating political awareness among the key national decision-makers.

### EXTERNAL INVESTMENT: DONOR SUPPORT

Direct external funding for elements of DOTS expansion is the classical form of programmatic donor support. Many NTPs have long benefited from such support, often with additional technical collaboration. Donor agencies more or less adopted programme components and were happy with the limited scope, clear objectives, and tangible results. Over time, considerable expertise has been acquired and mutual trust developed. If such support can be sustained over the long term, it can be the focus for the whole programme to grow. If projects are to thrive they must not rely too heavily on "external" skills, but rather establish external collaboration that benefits the development of national assets. In order to achieve a better balance of external and internal resources, the skills of the stakeholders may require development.

However, when the programme is expanding dramatically because of the increasing TB burden (e.g. increase of HIV/AIDS and/or MDR-TB), the need for additional resources becomes urgent. New donor agencies that wish to support components of the DOTS expansion plan are most welcome, but there is a risk that only those parts of the plan that are attractive to the donor will be selected for direct funding. Less attractive components may be left out, so that an imbalance develops between the various components. Another potential danger is that the funding of the plan can become divided between too many agencies, each with its own rules and regulations. Securing continuous support from multiple agencies requires significant public relations efforts.

## GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

The advent of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) is a new chapter in the financing of the fight against these three diseases. The promise of unprecedented funds is extremely heartening for programmes with very limited budgets; nonetheless, it is wise to remain realistic in terms of what is really necessary and how the money should be allocated. Not all the problems of DOTS expansion can be solved with money – the lack of human resources, for example, will not be cured overnight simply by a large injection of cash. Likewise, introducing expensive routines and procedures that cannot be sustained once GFATM funding stops are counterproductive in the long run.

Of the three diseases that are specifically earmarked, TB has an advantage in many countries, in that well developed plans exist for its control: DOTS expansion plans provide an excellent framework for this kind of investment. It is therefore important for NTP managers to make the most of this opportunity and carefully examine the conditions of the grant. A successful proposal for the GFATM requires a thorough understanding of the intentions of the fund, and NTP managers should not hesitate to ask for assistance from technical collaborators, including WHO. The GFATM clearly stipulates that funds must directly benefit communities struggling with a high TB burden. A national partnership is considered by the GFATM to be a significant national asset worthy of support (see also Chapter 2) and is referred to as a Country Coordinating Mechanism (CCM); proposals deriving from CCMs will be given preference. The efforts invested in building a national partnership can therefore yield significant benefits. As each country can only have one CCM that deals with the three diseases at the same time, the national TB partnership must position itself strategically to become part of the CCM building process.

The GFATM also stipulates that its funds must not replace existing commitments, either national (through the budget) or international (through donor agencies). Presenting a clear picture of the overall funding position will greatly enhance the credibility of the proposal.

## UN-EARMARKED INVESTMENTS FOR HEALTH IN GENERAL THAT CAN BENEFIT DOTS EXPANSION

Over the past 10 years, many bilateral donors have shifted their focus from project funding to a sector-wide approach (SWAp). This type of funding stimulated radical reform in many countries and a change in the role of government in relation to nongovernmental health care providers (Hanson, 2003). For many TB programmes this had a considerable impact on how they operate and how they access national resources (Hanson, 2003).

By providing support via the SWAp mechanism, donors wish to increase the national capacity to make informed decisions regarding the allocation of resources within the sector and thus stimulate the priority-setting process. The priorities must reflect morbidity and mortality patterns, with special emphasis on diseases that particularly affect the most vulnerable population groups. To avoid fragmented funding of the whole sector, many donors have begun to pool their resources and to make joint decisions on financing. If NTP managers are not actively engaged in the sectoral decision-making process (SWAp), there is every chance that their programmes will be overlooked (Bosman, 2000).

Since this type of funding lacks special earmarking, it allows unrestricted spending within the approved DOTS expansion plan. In addition, because these funds show up in the national accounts, the programme's profile is politically enhanced. By engaging NTPs in sectoral dialogues with international donors, opportunities emerge for DOTS expansion to take a more significant piece of the donor "cake". Macro-support for the entire health sector can result in significantly increased resources for DOTS: the Poverty Reduction Strategy Programme (PRSP) of the World Bank is an example. Tuberculosis control programmes can benefit greatly from this funding if they position themselves strategically in the health sector. This strategic positioning requires astute overall health sector management that maintains constructive relations with the Ministry of Finance, which normally conducts the negotiations for this programme. An NTP manager who is also a committed health sector advocate can have a significant impact that can directly benefit DOTS expansion.

## MANAGING RELATIONS FOR INVESTMENTS

Types of investment for DOTS expansion are summarized in the following table.

| Type of investment | Partners | Advantages | Disadvantages |
|---|---|---|---|
| ***National*** | MOH, MOF | Sustainable support | At times discrepancy between budget and actual available funds |
| ***International*** | | | |
| Earmarked | Donors GFATM | Packages with clear products Broad funding | - Fragmented support<br>- Conditionality<br>- Future unpredictable<br>- Fiscal year and budgetary cycle differences |
| Un-earmarked | MOH–MOF SWAp partners | Funding for all planned activities | - Dependent on political will and strategic skills<br>- Dependent on international political relations |

The national partnership can influence negotiations to ensure that the donor base is consistent with national priorities. Once the NTP has positioned itself strategically, with powerful partners, it will be able to negotiate from a position of strength.

## POTENTIAL PARTNERS FOR INVESTMENT

- *Bilateral donors include:* DFID, USAID, CIDA, Netherlands, Italian Cooperation, NORAD, SIDA, FINNIDA, Germany (GTZ and KfW), Swiss Agency for Development Cooperation.

  It is important to find out whether any of these agencies include health in their country programme as marked differences occur in the policy priorities for different countries.

- *Financial institutions include:* World Bank, GFATM, African Development Bank, Asian Development Bank, European Commission.

  The Treasurer of the Ministry of Finance normally manages contacts with these institutions, and further information can be obtained from the resident representatives.

- *International agencies that can assist as an intermediary to solicit support include:* Regional Stop TB Partnership (located in the WHO regional office), Global Stop TB Partnership Secretariat in Geneva, WHO Stop TB Department (DOTS Expansion Working Group), IUATLD in Paris, and KNCV in The Hague.

# ADVOCACY

## THE VALUE OF ADVOCACY

Traditionally, external assistance is thought of only as technical or financial support – its potential capacity for advocacy is virtually unexplored. The activities of most donor agencies are backed by well developed agendas and are internationally recognized for the wide coverage they achieve. These agencies are therefore able to increase national and international awareness of the TB programme. The Global Stop TB Partnership, which provides an excellent example of international advocacy, started the international movement to fight TB. Its efforts resulted in greater awareness at the highest levels, increased resource mobilization for TB control, and the setting up of the TB Global Drug Facility. At national level, the NTP can make use of this potential by using Global Stop TB partners for specific assignments.

At a national level too, such advocacy can produce positive results. If the programme has a good strategy and track record, many of these external assistance partners can be quite effective ambassadors when they discuss broader issues with the government.



An influential ambassador often finds more sympathetic ears among high-level decision-makers than an NTP manager would be able to find on his or her own.

# MONITORING AND EVALUATION

## THE VALUE OF MONITORING AND EVALUATION

All serious donor agencies require that the activities they support are monitored and evaluated – even though monitoring and evaluation (M&E) are sometimes seen as rather cumbersome processes. With many different partners involved it is essential that all inputs are checked and their impact measured. Conditions may change over time, in some cases quite dramatically. Assumptions made during the planning process may later prove to be ill-founded or wrong. Scheduled monitoring and evaluation will allow changes and adjustments to be made to the strategy in the light of actual conditions.

## THE PRINCIPLES

A structured approach is needed if the maximum benefit is to be derived from M&E. These are technical activities, not primarily concerned with financial audit of the programme.

The key issues for M&E must be identified during the planning stage, and WHO has produced a very useful guideline for monitoring technical progress (Kumaresan, Luelmo & Smith, 1998) that can be adapted to local conditions. Most of the data on technical progress are collected during routine recording and reporting. The more complete and accurate these data are, the more M&E can be simply be a question of their verification and the less intrusive the exercise will be.

It is important that all partners are actively involved in the preparation and performance of M&E activities and the drafting of findings and recommendations. The partners need this information to advise the bodies they represent on the value of their investments and to alert them promptly to any interim changes that may result from M&E recommendations.

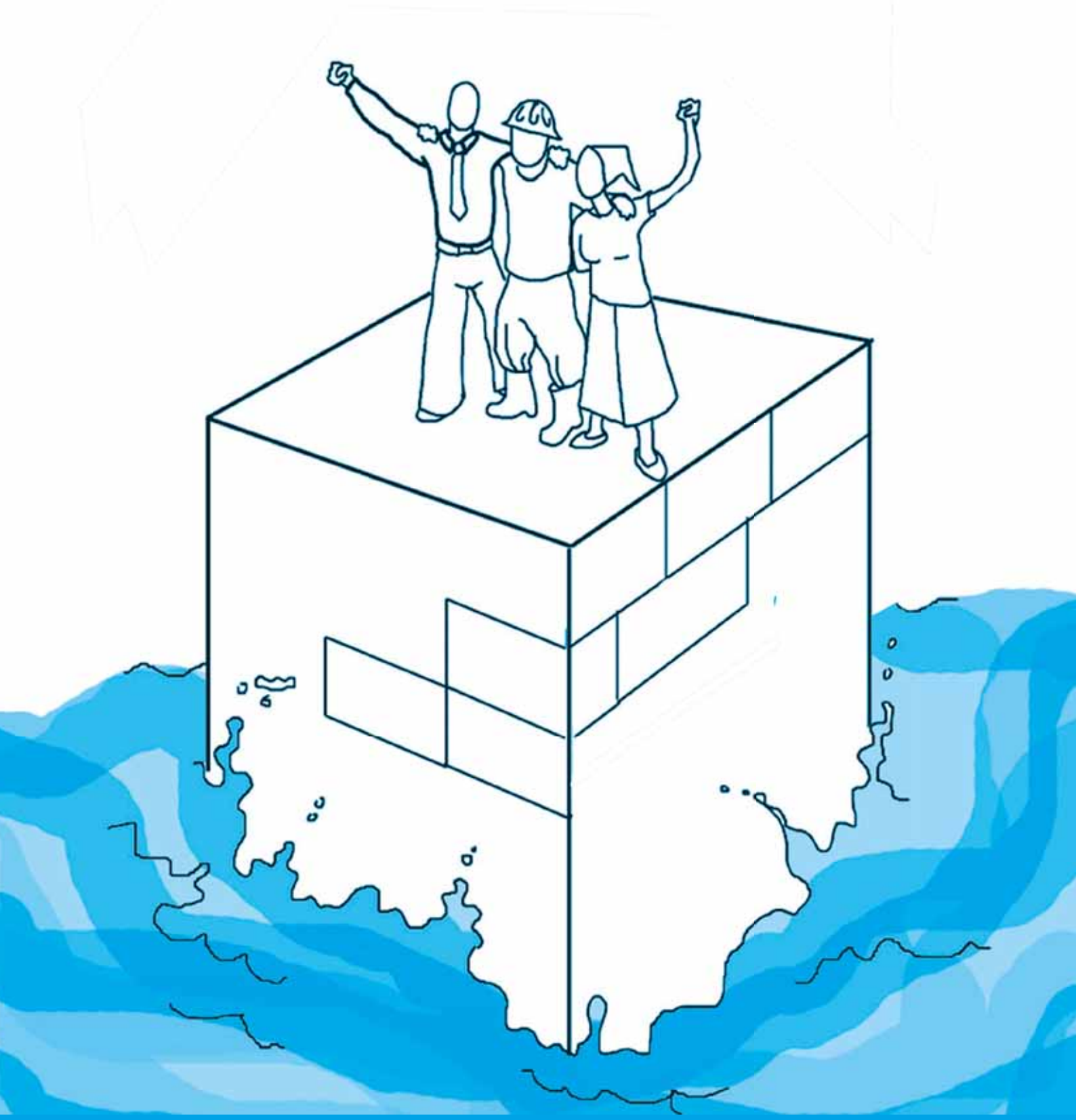
## JOINT MONITORING AND EVALUATION

In the absence of clear M&E procedures and schedules, some donor agencies may organize separate missions to find out for themselves how their support was used. However, such missions are often time-consuming and distract staff from other important tasks. For the sake of good relations with donors, the missions are welcomed, but most countries would appreciate separate missions being avoided. By including M&E in the DOTS expansion plan it becomes feasible to carry out joint activities – and the agreement of all partners to the principles of the DOTS expansion plan implies their agreement to joint M&E. The role of the NTP is then to finalize arrangements for regular single missions as detailed in the DOTS expansion plan. Drafting the Terms of Reference (TOR) for the M&E mission and circulating them to the partners is the first step. This will allow each partner to identify its most appropriate representative and to have an input in the overall process, thus facilitating the general acceptance of the outcome of the mission. The NTP will ensure that the relevant data are made readily accessible.

By making proper arrangements well in advance, the programme can reap significant benefits from the M&E mission for the continuation of the programme. On the other hand inadequate or poor preparation can easily lead to irritation among the partners and can even result in conflicts among them on how to proceed. This is certainly to be avoided as the programme then becomes very vulnerable to external manipulation.

## FOLLOW-UP AND THE NEXT STEPS

The drafting and publication of the M&E findings and recommendations are important and should not be overlooked. However, an over-long list of recommendations may easily defeat the purpose of providing a proper direction for the continuation of the programme. If the key issues are included in the TOR, the findings can focus on the priorities and provide useful recommendations. Good publicity for the findings and recommendations will win credibility for the programme and highlight its transparency: even shortcomings, if managed in a positive way, can help in securing additional support. With external expert backing, the programme will be in a much stronger position with regard to additional resource mobilization should this be necessary.



# CHAPTER FIVE

## The new role for national TB programmes

# ROLE OF NTP MANAGERS



The traditional role of the NTP manager is that of technical manager of the programme. This implies that he or she ensures that activities are carried out according to plan and that the quality of these activities is in line with the expected performance. The logistic management of resources (drugs and other supplies) is also the responsibility of the NTP manager.

With the growing number of partners providing broader support, the overall scope of the NTP manager's responsibilities has expanded. The national partnership requires close attention and the partners that carry out activities need support and guidance to ensure that all activities serve their intended purposes. The new role of the NTP manager thus involves interacting with institutions and agencies outside the direct authority structure of the programme. It is critical to to win the confidence and respect of these bodies – a passive and uncommunicative NTP manager will soon lose credibility to the potential detriment of the programme's performance. An effective partnership manager needs to provide relevant information, report on achievements, provide members with continuing education opportunities and group activities, and hold social gatherings for partnership members as appropriate (El Ansari & Phillips, 2001d). He or she must make people feel welcome at meetings, seek out and encourage the views of others during meetings, and invite input from outside the partnership.

The leadership qualities required are different in the different stages of the partnership. For instance, during the initial phase, when many partners need to be brought together and to become comfortable as part of a group, the NTP manager's charisma will be decisive. Thereafter, entrepreneurial abilities will be necessary in order to develop successful grant proposals. Later, the project will benefit from a leaders with skills in organization, management, and implementation. More routine managerial and administrative skills are essential throughout the partnership.

In addition to traditional abilities, an NTP manager must have good communication skills and the ability to interact with a wide spectrum of agencies, promoting equal status for all partners and encouraging overall collaboration in the member organizations. While some of the interaction skills can be acquired, the NTP manager's personal commitment is vital component for the success of the partnership. However, in certain cases, it is worth considering the value that communication specialists can add to national partnerships. A good example is the emerging need for NTP managers to interact with journalists and media-persons. Mass media play a critical role in informing the public and in framing political agendas. Unfortunately, these media are increasingly disinterested in poverty-related public health issues. Therefore, skilful engagement with media-persons becomes a critical task for NTP managers.

It is desirable that partnership managers and leaders have adequate personal resources such as an appropriate level of education and political insight, commitment and competence as well as being supportive to other organizations. They need to have a broad understanding of the health care system and as leaders they must be able to develop strategies to influence the features of the health system. They should network, build strong political ties to sustain the project while working with institutions, communities, donors and other actors. Effective leadership increases the potential of the partnership.

Managing external relations requires, first of all, a good understanding of the dynamics of each partner. Unfortunately, too often the manager is mainly concerned that partners understand his problems and he does not take time to find out what other parties are interested in. Making an assessment of each partner, using the framework below – *as an example* – can assist in determining the needs for interaction.

| PARTNER | PRIME INTEREST | VALUE FOR DOTS | PARTNER NEEDS |
|---|---|---|---|
| Bilateral donor 1 | Reduce poverty | Funding and support | TB poverty focus |
| Bilateral donor 2 | Improve health | Funding and support | TB as health status |
| International agency 1 | Reduce TB | Technical advice | DOTS indicators |
| International agency 2 | Health infrastructure | Funding | Utilization |
| Global initiative | TB control and care | Funding | Meet targets |
| Local NGO 1 | Health services | DOTS Expansion | Support and supplies |
| Local NGO 2 | Advocacy | IEC/COMBI | Support and advice |
| Other departments of MOH | Health services | Integration | Sharing resources |
| MOF Treasurer | Budget | Local funding | Financial reports |

# NATIONAL TB INTERAGENCY COORDINATION COMMITTEE



Many NTPs in high TB burden countries are supported by several donor agencies or international NGOs. The overall management of such programmes is generally coordinated by a national management committee. Although some committees have a fairly narrow scope (only TB control), they can be the starting point for expanding the NTP's base of interest. Members of bilateral and multilateral donor agencies who also participate in donor coordination meetings, such as SWAp health committees and PRSP platforms are also worth approaching to gain the interest of the management of the entire health sector.

After acceptance of the DOTS expansion plan, the NTP national management committee acquires formal status as the NICC and gains recognition at the highest national level. The findings and recommendations contained in the plan will have a greater impact when presented to key departments in the national government.

The initiative for forming the NICC should come either from the NTP manager or from the lead agency for TB control. To demonstrate that a national coalition of Stop TB partners is effective, it is vital that the structure is well described and that details of each partner's involvement are included. The structure must be documented in agreed TOR and substantiated with at least a joint letter of intent signed by all partners. In some countries the NICC may develop formal Memoranda of Understanding with each partner. All meetings must be planned well in advance to ensure the best possible attendance, and the NICC secretariat must ensure that minutes are kept of all meetings and made available before the next meeting. The minutes can reflect the contents of the discussions, but the conclusions and decisions should be summarized in a simple table as an administrative log or record (see example below) that will help the actual follow-up.

| Decision | Action partners | Achievement indicator | When completed |
|---|---|---|---|
| Advocacy for DOTS | PR Agency | Advocacy plan ready | June |
| Procurement drugs | NTP, MOF | Drugs in national store | December |
| NGOs to join reporting | Religious NGO | NGO institutions report to NTP | May |
| DOTS in medical curriculum | Medical association | Curriculum revised | January |
| TB part of SWAp | NTP, MOH and bilateral | DOTS expansion included in the SWAp evaluation | August |
| Mobilization of resources | NTP, MOF, KNCV | Adequate additional resources secured | December |
| Next meeting | NTP | Invitations sent | July |

In countries where the participating partners are few or do not have a national TB management platform, additional guidance from international TB programmes will be necessary. Important lessons can be learned from other donor-coordinating mechanisms. Examples of groups that can be contacted for support include: the SWAp health committee, health sector reforms steering group, donor coordinating forum for the health sector, and health basket financing committee.

It must be realized that interagency coordination cannot work in isolation from other similar initiatives. Developing close links with coordination activities in the health sector are essential to ensure that all activities harmonize with both the overall national policy and the general donor consensus for support of the health sector. Finally, a partnership that is not formally recognized will soon deteriorate and become a group of interested parties with no real commitment or future. Neither partners nor national authorities would feel obliged to follow the decisions of such a group. It is therefore important that the structure and the decision-making process are well defined and that the mandate of the partnership is fully recognized by the relevant national authorities and partners. Some partnerships resemble agency "get-togethers" where partners get to know each other only superficially. In more successful partnerships, operating responsibilities are carefully detailed and divided among partners.

**IS THE NICC FORMAL?**

- Does it have a written mission statement?
- Does it have written bylaws or operating principles?
- Does it review its bylaws or operating principles periodically?
- Does it have written objectives?
- Does it review its mission, goals, and objectives periodically?
- Does it engage in strategic planning?
- Does it have a long-range plan beyond the initial funding?
- Does it have specific coverage of fundraising?
- Does it have clear procedures for leader selection?
- Does it provide orientation for new members?

**IS THE NICC FUNCTIONAL?**

- Have you brought all partners together to discuss the national DOTS expansion plan?
- Are there Terms of Reference for the NICC?
- Do you have a formal commitment from all members to the aims and objectives of the NICC?
- Do you have criteria for accepting/rejecting membership of the NICC?
- Is the most senior MOH official committed to chair the NICC?
- Do higher authorities in government officially recognize the NICC?
- Is there a committed secretariat for the NICC?
- Are you meeting at least twice a year?
- Do you keep minutes of the meetings and an administrative log?
- Is there an arrangement for periodically reviewing the performance of the NICC?

**ARE THE NICC MEETINGS PRODUCTIVE?**

- Do meetings start and finish on time?
- Is the purpose of each task or agenda item defined and kept in mind?
- Are technical terms clearly defined and understood by all?
- Are routine matters handled quickly?
- Are subcommittee findings and other reports routinely made available to the entire partnership?
- Are materials for meetings (agendas, minutes, study documents) adequately prepared in advance?
- Do minutes accurately reflect the proceedings of the meetings?
- Is notification of meetings timely?
- Do members have a good record of attendance at meetings?
- Does everyone participate in the discussions, rather than just a few people?
- Do members stay focused on the task at hand?
- Is interest in the partnership generally high?
- Is the atmosphere friendly, cooperative and pleasant?
- Do meetings run smoothly without interruptions?
- Is the location of meetings convenient?
- Do meeting times work well with the stakeholders' schedules?

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# ANNEXES

# UNDERSTANDING PARTNERSHIPS
## A conceptual framework

B

### PERSONNEL FACTORS

**Expertise:** proposal writing, administrative, managerial/ organizational, entrepreneurial
**Experience:** of joint working and particularly on a partnership basis
**Operational understanding:** how members are appointed, how committees are formed
**Benefits:** gaining of skills, knowing more agencies, reaching target beneficiaries
**Costs:** time, effort, in-kind resources, opportunity costs, psychological costs
**Benefit–cost ratio:** ratio of the benefits to the costs of participating; is it worth it?
**Sense of ownership:** feeling that no outsiders control the partnership
**Role consensus:** clarity of roles, responsibility, duties
**Satisfaction resource allocation:** how are funds distributed in the partnership?

### PERSONNEL BARRIERS: MEMBER AND STAFF

**Priorities:** of individual agencies in relation to those of the partnership
**Expertise:** are the required skills available in the participating constituencies?
**Availability:** for meetings, projects and programmes, activities
**Turnover:** new faces welcomed but require clarification and updating
**Interest:** over a long time period – how can member interest be sustained?
**Interest:** in general partnership activities

### POWER-RELATED FACTORS

**Power disparities:** rivalry, pressure tactics and groups, non-transparency
**Culture of the agencies:** will determine the values of stakeholders
**Vision:** required early, collective, acts as guiding beacon for mission and constitution
**Accountability:** multiple agencies, voluntary participation, accountability not clear
**Transparency:** critical for successful partnerships at all stages, related to honesty
**Change-management:** partnerships usually promote change
**Group dynamics and interaction:** partnership's asset is teamwork
**Stakeholder tensions:** grievance mechanisms, problem-solving/conflict-resolution skills

### ORGANIZATIONAL FACTORS

**Rules and procedures:** mission, byelaws, operating principles
**Community representation:** of most sectors, agencies, constituencies, community organizations
**Communication quality and mechanisms:** written, verbal, channels of dissemination
**Interaction:** dominant groups, assumption of leadership, political considerations
**Decision-making:** participation in and influence on decisions
**Management capabilities:** public speaking, organizing meetings, minutes, democratic consensus
**Information flow:** regular, relevant, informative, comfortable, and timely?
**Leadership capabilities:** social, political, administrative, delegable

### ORGANISATIONAL BARRIERS

**Competing priorities:** vision of the partnership agreed upon by all stakeholders?
**Funds and fundraising:** sufficient funds? Duration of funding period, sustainability
**Goal-setting and decision-making:** democratic, consensus, dominated?
**Coordination and communication:** overlaps, duplication, fragmentation, "bad timing"
**Credit for activities:** competition between initiating agency and the partnership
**Assumption of leadership:** by consensus, any power struggles?
**Stakeholder differences:** philosophy, structure, financial rules or service areas
**Lack of participation:** low participatory quality, low morale, boycotting
**Public relations and media:** are the partnerships receiving attention?

### OTHER FACTORS

**Scope of partnership:** health is seldom a priority – community development appealing
**Number of partners:** obstacles increase with increased stakeholders
**Number of problems:** is the partnership too broad in focus, too ambitious?
**Simplicity of language:** minimal technical jargon, "plain" English
**Procedural delays:** initial financial constraints, fiscal obstacles between agencies etc.
**Timeframes/funding cycles:** objectives chronologically congruent with funding period?
**Sustainability:** need to be thought of early, secondment of posts, alternative funding
**Institutionalization:** partnership operations in participating agencies becoming routine
**Human factors:** open-mindedness, negotiating skills, tolerance, patience, persistence
**Personal traits:** confidence, good relationships, respect, sensitivity
**Motivation:** what motivates people?

**SATISFACTION AND COMMITMENT**
**EFFECTIVENESS AND OUTCOME EFFICACY**
**ACTIVITY AND EDUCATIONAL ACTIVITY**

**ACHIEVEMENT**
**IMPACT**

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# NTP PARTNERSHIPS IN ACTION
# COUNTRY EXPERIENCES



## PERU'S EXPERIENCE

Peru's DOTS expansion history began in the early 1990s, with a spontaneous street demonstration by TB patients calling for access to effective drugs. The positive political response to these demands became the main driving force for all departments and organizations to become jointly engaged, using the national DOTS expansion plan as the strategic guideline.

The national TB programme (NTP) of Peru has had a significant impact on the TB epidemic countrywide and has been using the DOTS strategy since 1990. With strong political support for reducing the TB problem, the NTP has successfully launched several deep-rooted TB control activities. A national response was formulated and provided the necessary impetus for building partnerships with other departments and organizations. Results have been impressive, and include the following:

- Improvement in diagnostic efforts contributed to a sharp increase in the case notification rate between 1990 and 1993.
- Since 1993, the number of new smear-positive cases has declined in all departments of the country.
- On average, decline in the notification rates for new pulmonary cases since 1993 has been 6% a year. This compares with a decline of 3.9% a year during the period 1966–1990.
- Between 1991 and mid-2000, the number of successfully treated smear-positive cases was 207 166.
- During the period 1991–2000, 158 000 pulmonary cases were prevented or 27% of the total number of expected new cases.
- Among smear-positive cases, 91 000 (70%) of expected TB deaths were averted.
- Peru has reached the targets of the Global Partnership to Stop TB for the year 2005, i.e. 70% case detection and an 85% cure rate.

Of all factors contributing to these results, the consistent political backing for this programme seems to stand out as the most important. Also the government expanded the coverage of the general health services, by constructing many new health centers. The political backing for TB control is illustrated by the TB control coverage of participating health centres increasing from 177 out of 737 (24%) in 1991 to 6539 out of 6552 (99.8%) in 1999. The number of laboratories performing smear microscopy increased from 307 in 1989 to 1200 in 2000. Such results clearly demonstrate just how instrumental government commitment is for DOTS expansion.

## WHAT CAN BE LEARNED FROM THE PERU EXPERIENCE?

- Patients can succesfully make reasonable and justifiable demands to politicians, and politicians can respond in an appropriate and supportive way.
- High-level political commitment resulted in a broad range of governmental actions aimed at DOTS expansion.
- The country's President made control of TB a high priority for government, thus providing the optimal setting for building partnerships as a national response to fight the disease.
- Funding for TB control increased.
- The central unit of the NTP was strengthened with the appointment of a dynamic manager.

Political will in Peru has been a key factor in DOTS partnerships on three fronts:

- **Social mobilization.** A mobilized community demanding services and achieving a high level of political commitment, combined with effective NTP leadership, created a favourable environment for close to 100% access to TB control.

- **Technically excellent programmes.** Benefits were derived from the introduction of standardized but flexible policies. In 1991, the NTP used a single anti-TB treatment scheme for all patients, irrespective of their previous treatment history. Since 1996, different treatment regimens have been used for new and previously treated patients, with direct observation of treatment. The cure rate for new patients has since increased from 50% in 1990 to 93% in 1999.

- **Well developed health infrastructure.** The country now guarantees to provide detection, diagnosis, and – at no cost – supervised treatment for TB in all health services.

D

## CAPACITY-BUILDING IN THE UNITED REPUBLIC OF TANZANIA

For many years, the near-total inability of the existing health system to meet the requirements of TB control had seriously endangered the status of the health sector in the United Republic of Tanzania. The will to improve this situation was a particularly strong force behind the important political and health sector reforms carried out, with significant donor input, in 1996. At that time, the country's national tuberculosis and leprosy control programme (NTLP) underwent considerable change, adapting to the sector-wide approach (SWAp) strategy as part of overall health sector reforms. The new policy stressed a decentralized form of government, with greater involvement of other national stakeholders, meaning that the programme would become a part of a larger entity and no longer have a clear separate structure.

The new programme manager started by calling all TB/leprosy stakeholders together and involving them in the formulation of a five-year plan. This plan clarified the programme's direction and attracted additional support from previously reluctant donors. The NTLP Management Committee (NMC) supervised the use of donor contributions for TB/leprosy and ensured that governmental contributions were also made available. It was very much a balancing act between the interests of the NTLP on one side and the entire health sector on the other. When the progress in the health sector reforms took longer than expected, it seemed likely that NTLP progress would be similarly slowed. However, the Permanent Secretary of the Ministry of Health chaired the NMC and, ahead of the health sector reforms, introduced new financial procedures geared to performance and budget control. In this way, the programme gained credibility as an innovative pilot for the whole reform process.

### SUCCESSFUL DOTS EXPANSION CAMPAIGN

Thanks to these strong initiatives, NTLP performance improved appreciably, setting an example for the rest of the health sector. With assured resources, both national and international, the NTLP continued to provide quality support for and engage other stakeholders in TB control. For example, under NTLP stewardship, the Dar es Salaam city council launched a successful DOTS expansion campaign. As overall DOTS coverage became more widespread, cure rates improved dramatically over a five-year period.

### IMPORTANT CONCLUSIONS FROM THE EXPERIENCE OF THE UNITED REPUBLIC OF TANZANIA

- Contributions to the planning and building of a national DOTS platform by all stakeholders will produce dramatic results.
- By engaging as an innovator in the health sector reform process, both the programme itself and the health sector as a whole can benefit.
- A highly motivated NTP manager, a shared vision among committed partners, and solid political support, can produce a rapid improvement in even severely deteriorating conditions.

## DEVELOPING A DYNAMIC ICC FOR CAMBODIA

The Cambodian NTP has been in operation since 1980 and, until 1993, used long-duration treatment strategies. In 1994 the government adopted the DOTS strategy, and in 1995 established the National Committee for TB Control. This Committee is headed by the Prime Minister, which clearly demonstrates the political commitment of the government. Throughout its history, the NTP has received external support from a wide range of donors. Initially, coordination of donor support to the entire health sector was organized through a national coordinating committee (COCOM), chaired by the Ministry of Health. Until recently, support to the NTP was part of the COCOM agenda.

In 1999, the Japanese International Cooperation Agency (JICA), the programme's main donor, proposed to the Ministry of Health the establishment of a specific TB coordinating committee for the NTP, as recommended by WHO. The purpose, framework, process, and mechanisms of a national TB Interagency Coordination Committee (ICC) were discussed in a number of meetings with the main stakeholders. During a Partners Coordinating Meeting in March 2001, attended by representatives of WHO, USAID, JICA, the Research Institute of Japan, the Japan Anti-Tuberculosis Association, the World Bank and NTP staff, it was decided to hold regular Coordination Committee meetings for TB with the following main aim:

> "To assist the National Anti-Tuberculosis Centre to successfully implement the NTP, by identifying potential donors, providing technical assistance, mobilizing and coordinating available resources, resolving issues, supporting advocacy and monitoring the progress made according to the 5-year country plan (2001–2005) to control tuberculosis in Cambodia".

The third meeting of partners changed the name from COCOM to ICC and reviewed the NTP progress report for the first half of 2001. Subsequent meetings in August and October 2001 reviewed the first and second draft of the NTP's 5-year strategic plan. The ICC has currently 15 members (WHO, MSF, World Bank, JICA, World Food Programme and others).

The input of the ICC contributed hugely to formulation of the national health policies and strategies for TB control in Cambodia and the strategic plan for TB control for the period 2001–2005. In addition, the members actively collaborated in many areas relevant to the success of the NTP and helped to strengthen the mechanism of coordination between the NTP and the donors.

## WORKING WITH MANY DIFFERENT STAKEHOLDERS TOWARDS A COMMON GOAL — THE RUSSIAN EXPERIENCE

Tuberculosis is especially problematic among specific population groups in the Russian Federation – the very poor, the homeless, and (ex)prisoners. For a country of this size, working together with many stakeholders (government departments, NGOs, and international agencies) is the way to move forward, sharing the enormous burden of fighting the disease. The Russian experience in building partnerships demonstrates the vital role of federal and regional governments, while acknowledging and actively involving the expertise and experience of the centres of academic excellence.

### HIGH-LEVEL WORKING GROUP

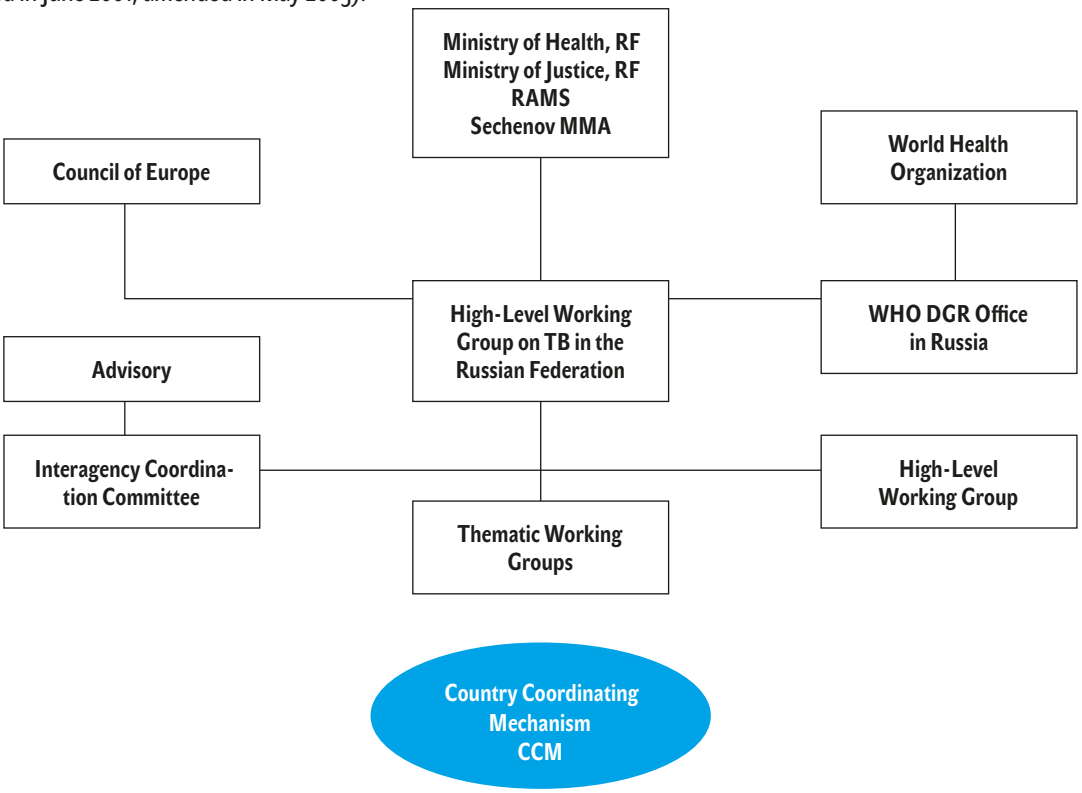
In early March 1999, a WHO delegation met with officials at the Ministries of Health and Justice, the Academy of Medical Sciences, the health committee of the Duma (parliament), and the Russian Red Cross. It was agreed to establish an interdisciplinary group, led by the Ministries of Health and Justice and WHO and made up of Russian and international TB experts. The overall aim of this group, the High-Level Working Group (HLWG), was to develop the best strategy for TB control in the Russian Federation.

The HLWG now has a broad structure, including the Interagency Coordination Committee as an essential mechanism for coordinating the activities of national and international agencies in the field of TB control. Interaction of all the HLWG components, their memberships, tasks, and functions are described in detail in the Statute of the High-Level Working Group on TB in the Russian Federation (officially approved in June 2001, amended in May 2003).

*One of the most significant achievements of the HLWG is development of the five-year development plan "Provision of Guaranteed Diagnostic and Treatment Procedures for TB Patients and Development of TB Services in Russia".* Development of this plan was discussed at the fourth HLWG meeting in June 2001, when its main goals, objectives, and components were presented. Establishment of the special Thematic Working Group (TWG) for elaboration of the plan was supported by the members of the HLWG. Experts from the Ministries of Health and Justice, Central Tuberculosis Research Institute of the Russian Academy of Medical Sciences (RAMS), and Research Institute of Phthisiopulmonology, Sechenov Moscow Medical Academy developed the major provisions of the plan, describing priorities in the organization of TB control measures and the improvement of TB services.

The HLWG approves specific TWGs on technical TB control issues. TWGs are made up of Russian and international experts and representatives of the leading TB institutes in the Russian Federation; each has a chairperson, a core group, and temporary experts and consultants. TWGs have been created for the following areas: Surveillance, Five-year TB Control Plan, TB in Prison, Laboratory, TB Surgery, TB Glossary, Extrapulmonary TB, TB and HIV/AIDS, TB in Children, Drug Procurement and Supply, Diagnosis, Treatment and Drug Resistance.

The TWG accomplished elaboration of the Plan in December 2002 and submitted it to the Russian and international partners; it was approved as the main framework for improvement of the TB services in Russia. The mechanism for implementation of the Plan was presented and discussed during the seventh meeting of the HLWG in May 2003.



Meetings of the HLWG are held twice a year and are attended by more than 200 representatives of stakeholder organizations. All Russian NGOs and entities that are active in TB control participate. In between HLWG meetings, the ICC builds on national consensus at federal level by sharing information and discussion. The ICC meets at least once a year and aims to follow through on the decisions of the HLWG and to set the priorities for the next HLWG meeting. The HLWG secretariat follows up conclusions and recomendations.

## INTERDEPARTMENTAL COLLABORATION AT THE REGIONAL LEVEL

In a number of regions of the Russian Federation, well-functioning Interdepartmental TB Control Commissions were established at the level of the Oblast administration to foster intersectoral collaboration in TB control. The Interdepartmental TB Control Commission is chaired at the highest political level – by the Governor or Deputy Governor – and consists of all major stakeholders involved in the field of TB (Finance Department, Health Department, Department of Sentence Execution (prisons), Social Support Department, Sanitary Surveillance Service, Press Department, Russian Red Cross, etc.).

The Commission meets quarterly and decides on TB control issues that are the responsibility of more than one department or sector. A Governor's Resolution is issued at the end of each meeting and new regulations are developed by the relevant departments to provide the legal basis for the decisions.

Concrete examples of this successful mechanism are: free bus transport to the place of diagnosis and treatment for TB patients; improved collaboration between civilian and prison sectors and between TB and general health care services; reactivation of the Social Support Department and Russian Red Cross in supporting vulnerable TB patients and their families. It is proposed that Interdepartmental TB Control Commissions should be established in all oblasts throughout the Russian Federation.

## LESSONS LEARNED FROM THE RUSSIAN EXPERIENCES

- Top-level political and government commitment is vital.
- Leadership must be in the hands of the national entity, accepted by all stakeholders.
- The diversity of expertise and experiences of different Russian stakeholders were carefully included in the whole process.
- Establishing a legal basis for the collaboration makes decisions binding and ensures progress.
- Including all national stakeholders is essential to ensure compliance with best practices.
- The carefully formulated Five-Year Plan provides TB control with concrete steps to follow and also serves as a resource mobilization tool.

## BUILDING TB PARTNERSHIPS: IN VIET NAM

Since the reunification of Viet Nam in 1975, the National Institute of Tuberculosis and Respiratory Diseases (NITRD) in Hanoi has been in charge of coordinating the NTP. The Pham Ngoc Thach (PNT) Hospital in Ho Chi Minh City is responsible for supervising TB control activities in the southern provinces of the country.

The first external partner of the NTP was the Medical Committee Netherlands–Vietnam (MCNV), an NGO from the Netherlands that was established in 1968 to provide humanitarian aid to the government in Hanoi during the Viet Nam war. In 1983, at the request of the Ministry of Health of Viet Nam, a team of Dutch experts visited the country to review the TB programme. As a result, the Ministry of Health officially launched the "new" NTP in December 1985 at an international conference. Attendees included representatives of the International Union Against Tuberculosis and Lung Diseases (IUATLD) and the Royal Netherlands Anti-Tuberculosis Association (KNCV) in Ho Chi Minh City.

Since 1986, the NTP has been expanding in a hierarchical pattern from province to individual village levels. The programme is integrated into the primary health care system, with general health staff at district and village levels responsible for diagnosis and treatment.

On the basis of a formal agreement with the Ministry of Health in Viet Nam, MCNV provided material and technical assistance to the programme. In collaboration with IUATLD, KNCV provided the necessary technical guidance. The WHO reference laboratory in Prague, Czech Republic, assisted the NTP by developing two reference laboratories, one each in Hanoi and Ho Chi Minh City. The International Tuberculosis Surveillance Centre in The Hague assisted with the design, execution, and analysis of tuberculin surveys.

### NATIONAL EXPANSION PROGRAMME INTRODUCED

Based on the development plan for 1994–1998, the Dutch Ministry for Development Cooperation agreed to support TB control activities in Viet Nam with the help of MCNV and KNCV. Representatives of these agencies visited Vietnam twice a year to provide independent assessment of programme implementation and to offer recommendations on further expansion plans

### TB — A NATIONAL PRIORITY

In 1995, Viet Nam declared TB control a national priority and concluded an agreement with the World Bank for a loan to be invested in the first National Health Sector Support Project. This Project included NTP support to achieve countrywide DOTS coverage. Funding from the loan contributed towards the cost of supplies, particularly anti-TB drugs, and operating and capacity-building expenses.

In May 2000, the development plan for 2000–2004 was published. Contributors to the plan included NTP staff from Hanoi and the PNT TB centre, with project planning support provided by KNCV and MCNV teams. The plan was developed in close collaboration with all external partners, i.e. World Bank, the Royal Netherlands Embassy in Hanoi, the Centers for Disease Control and Prevention (CDC) in Atlanta, USA, WHO representatives in Hanoi, and MCNV and KNCV.



### ROUND TABLE MEETING LAUNCHED ICC

The plan was launched during a round-table conference in which all stakeholders participated. This meeting was de facto the first meeting of the NTP's Interagency Coordinating Committee (ICC); a second formal meeting was held in 2001. Since establishing the ICC concept, the NTP has held several meetings and joint missions with external partners. Mission reports of individual partners are sent to all ICC members, and individual members keep in regular contact through e-mail.

Establishing the ICC has proved to be an important step for NTP management and growth. In 1996, a subcommittee was established to determine research priorities and to appraise projects submitted by different organizations. Current members of the ICC are the NTP/PNT, Hanoi School of Public Health, Medical Schools of Hanoi and Ho Chi Minh City, the World Bank, CDC, KNCV, MCNV, the Royal Tropical Institute of Amsterdam, the Karolinska Institute, and WHO.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