STOP TB PARTNERSHIP
EXTERNAL EVALUATION

5 JUNE 2015

FINAL REPORT - ANNEXES

Submitted by:

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CEPA

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ANNEX 1 BIBLIOGRAPHY

This annex presents the list of documents and datasets consulted for the assignment.

Documents

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ANNEX 2 CONSULTATIONS

Table A2.1 lists the consultations carried out for the evaluation.

Table A2.1: List of interviewees

Stakeholder	Name	Organisation/ Position
Stop TB Secretariat	Lucica Ditiu	Executive Secretary
	Suvanand Sahu	Deputy Executive Secretary
	Anant Vijay	Special Advisor
	Joel Keravec	GDF Manager
	Jacob Creswell	TB REACH Team Leader
	Khaya Matsha Carpentier	Global Fund Engagement Team leader
	Jon Liden	Strategic Planning and Advocacy Team Leader
	Nejib Ababor	Administration and Finance Team Leader
	Elisabetta Minelli	Partnerships Officer
	Jennifer Dietrich	CFCS Technical Officer
	Giuliano Gargioni	Former Interim Executive Secretary
Board members - *Donors*	Erika Arthun	Senior Program Officer, Bill and Melinda Gates Foundation
	Michael Kimerling	Senior Program Officer for TB, Bill and Melinda Gates Foundation; Coordinating Board member
	Amy Bloom	Senior Technical Advisor, US Agency for International Development; Former Coordinating Board Interim Chair
	Nathalie Garon	Senior Development Officer, Canadian International Development Agency
	Nichola Cadge	Health Adviser, UK Department for International Development; Coordinating Board member
	John Moncrieff	Policy Administrator, UK Department for International Development
Board members - *Multilaterals*	Mark Dybul	Executive Director, Global Fund to Fight AIDS, Tuberculosis and Malaria; Coordinating Board member
	Eliud Wandwalo	Senior Disease Coordinator, Global Fund to Fight AIDS, Tuberculosis and Malaria
	Mohammed Yassin	Senior Disease TB Adviser, Global Fund to Fight AIDS, Tuberculosis and Malaria
	Mario Ravaglione	Director of the Global TB Programme, WHO; Coordinating Board member

Stakeholder	Name	Organisation/ Position
Board members - *NGOs and communities affected by TB*	Joanne Carter	Vice-Chair, RESULTS US; Coordinating Board Vice-Chair
	Aaron Oxley	Executive Director, RESULTS UK; Coordinating Board member
	Blessi Kumar	Chair, Global Coalition of TB Activists (GCTA); Former Coordinating Board Vice-Chair
	Thokozile Beatrex Nkhoma	SAVE National Coordinator, Malawi Interfaith AIDS Organisation; Coordinating Board member
	Austin Obiefuna	President, AFRO Global Alliance (Ghana); Coordinating Board member
Board members - *Technical agencies*	Ken Castro	TB Division Director, CDC; Former Coordinating Board member
	Paula Fujiwara	Scientific Director, The Union; Coordinating Board member
Working Group representatives	Alessandra Varga	Secretary for the New Diagnostics Working Group, FIND
	Karin Weyer	Secretary for the Global Laboratory Initiative and the Global Drug-resistant TB Initiative, WHO
Other stakeholders	Naina Dhingra & Casey Enders	McKinsey & Co.
	Thomas Teuscher	Senior Advisor for Policy, Strategy and Governance, Roll Back Malaria

ANNEX 3 INTERVIEW GUIDE

This annex presents the interview guide used for consultations with stakeholders. The guide provided an introduction to the evaluation, which has not been included here for brevity.

Consultation questions for discussion

Relevance and comparative advantage

1. What is the relevance of the Stop TB Partnership in relation to the global/ country needs and gaps for TB control? Are there particular aspects of the Partnership's mandate, approach and areas of focus that make it well-placed to support TB control efforts?
2. What are the comparative advantages of the Partnership as compared to other global players working on TB control (e.g. the Global Fund, WHO TB Department, the Union, KNCV, etc)? Has the Partnership been successful in leveraging its comparative advantages over the 2007-13 period?

Implementation performance

3. What has worked well and not so well in the Partnership's activities on:
    a. partnership building;
    b. advocacy and communication;
    c. TB REACH; and
    d. GDF
4. Have the Stop TB Partnership governance/ management arrangements been efficient and effective (Board and its Committees, Working Groups, Partners Forum)?[1]
5. How has the Stop TB Partnership Secretariat performed in terms of delivering on its roles and functions? What might be its key strengths and areas for improvement?
6. How has the Partnership performed in terms of its accountability and transparency to its partners and key stakeholders?

Results

7. What is your view on the effectiveness of the Partnership's M&E arrangements? What works well and what might be areas for improvement?
8. What have been the main results of the Partnership over the period 2007-13?
    a. To what extent has the work of the partnership been "catalytic", "facilitating" and "innovative"? Please provide examples.

[1] We understand that recent reforms have been introduced for the Board and Working Groups and we would like to discuss the context for these changes and any issues that may remain.

b. To what extent have the Stop TB Partnership activities over the period 2007-13 contributed toward the achievements of the Global Plan 2010-15?

Value for money

9. Do you think the Partnership offers value for money to its donors? Why/ why not? What would you suggest as the main evidence to support value for money of the Partnership?

Recommendations

10. What are your key 3-4 recommendations to improve the value for money of the Partnership? Areas for suggestions might include: how the Partnership might increase its relevance, how might it function more effectively and efficiently, what more the Partnership could do to support the Global Plan objectives, amongst others.

ANNEX 4 MAPPING OF THE GLOBAL TB CONTROL ARCHITECTURE

This annex presents a mapping of the key global organisations working on TB care and control, to support our review of the comparative advantage of the Stop TB Partnership.

Our landscape review encompasses a range of organisations including donors (bilateral, multilateral, foundation), international NGOs and technical organisations. At a high level, we have categorised these organisations into four main groups: (i) funding/financing; (ii) technical assistance; (iii) research and development; and (iv) advocacy – based on their main role, although we recognise that some organisations have multiple roles and could fit into several categories.

We have mapped the following features of each organisation's role in the global TB landscape:

- *Overall mandate/ objective* – based on their stated mission;
- *Activities* – categorised into six types: (i) funding/ financing; (ii) technical assistance; (iii) research and development; (iv) advocacy; (v) coordination; and (vi) market-dynamics;
- *Areas of focus on TB* – highlighting if the organisation has a specific focus within TB e.g. TB-HIV co-infection, MDR-TB, etc.;
- *Level of funding* – based on the latest available funding figures for 2013, where available; and
- *Geographic focus* – global, regional or specific countries.

Table A4.1 below provides the full details.

Table A4.1: Global TB landscape

Organisation	Mandate/ Objective	Activity focus	Area of focus	Funding in 2013, US$ m	Geographical focus
Funding / financing					
Global Fund	"To attract, manage and disburse additional resources to make a sustainable and significant contribution in the fight against AIDS, tuberculosis and malaria in countries in need"[2]	• **Funding/financing** The Global Fund (GF) provides grant-funding for country-based diagnosis and treatment projects. The GF piloted a New Funding Model in 2013, which was fully implemented in 2014. The Model was intended to offer "predictable funding, to reward ambitious vision, to work on more flexible timings and with a smoother, shorter process that ensures a higher success rate of applications."[3]	TB control programmes in countries	$588[4]	Global
United States Government – U.S. Agency for International Development (USAID)	"Increasing Access to TB Care, Prevention and Treatment"[5]	• **Funding/financing** • **Technical assistance** USAID is the lead agency for funding international TB care and treatment activities and supports a comprehensive response to TB, TB/HIV, and MDR-TB through national TB care and treatment programs in host countries.	TB control programmes in countries	$236[6] (This figure includes disbursements delivered under PEPFAR)	27 lower or middle-income high-burden MDR-TB countries: Afghanistan, Bangladesh, Cambodia, DR Congo, Ethiopia, Georgia, Ghana, India, Indonesia, Kazakhstan, Kenya, Kyrgyz Republic, Malawi, Mozambique, Namibia, Nigeria, Philippines, South Africa, South Sudan,

[2] Global Fund Strategy Framework 2012-16, p.5
[3] Global Fund "New Funding Model Brochure", p.2
[4] Global Fund Annual Report 2013
[5] US Government report on international foreign assistance for Tuberculosis, p.6
[6] US Government report on international foreign assistance for Tuberculosis, p.13

Organisation	Mandate/ Objective	Activity focus	Area of focus	Funding in 2013, US$ m	Geographical focus
					Tajikistan, Tanzania, Turkmenistan, Uganda, Ukraine, Uzbekistan, Zambia, Zimbabwe.
US Government – President's Emergency Plan for AIDS Relief (PEPFAR /Office of the Global AIDS Coordinator (OGAC)	To "target HIV-associated tuberculosis (TB) and reduce co-morbidity and mortality"[7]	• **Funding/ financing** • **Coordination** PEPFAR is a commitment on behalf of the US Government to fighting the global AIDS epidemic. Several implementing agencies carry out the Plan's activities. The Office of the Global AIDS Coordinator (OGAC) is the lead agency for coordinating the US Government's response to TB/HIV co-infection under PEPFAR. Actual funding activities are carried out by USAID.	HIV/TB co-infection	N/A	PEPFAR has country operational plans for: Angola, Asia Regional, Botswana, Burma, Cambodia, Cameroon, Caribbean Regional, Central America Regional, Central Asia Regional, Côte d'Ivoire, Democratic Republic of the Congo, Dominican Republic, Ethiopia, Ghana, Guyana, Haiti, India, Indonesia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Papua New Guinea, Rwanda, South Africa, South Sudan, Swaziland, Tanzania, Uganda, Ukraine, Vietnam, Zambia, and Zimbabwe.
World Bank	"Support to Health Nutrition and Population (HNP) is targeted to the reduction of communicable	• **Funding/financing** • **Technical assistance**	TB programmes in countries –	$23.5[9]	Global

[7] PEPFAR Blueprint, p.26: Action Step 1 of PEPFAR's Road Map for Smart Investments

[9] World Bank "Projects" page: http://www.worldbank.org/projects/search?lang=en&searchTerm=&themecode_exact=93

Organisation	Mandate/ Objective	Activity focus	Area of focus	Funding in 2013, US$ m	Geographical focus
	diseases among the poor… through staffing reforms, pharmaceutical policy, and sustainable and equitable financing. The Bank's assistance strategy is focused on creating an enabling environment for providing cost-effective interventions that are best implemented by the development partners."[8] The Bank finances TB control projects through the International Development Association (IDA).	The Bank finances TB control directly with predictable medium to long-term loans, but also by supporting tobacco control measures, health systems strengthening, and the improvement of public housing and environment. The Bank supports full-scale implementation of the WHO-recommended "Directly Observed Treatment Strategy" (DOTS). The World Bank has financed 66 projects with a TB control element to-date: 48 through the International Development Association (IDA) and 18 through the International Bank for Reconstruction and Development (IBRD).	focusing on "upstream" policy development and capacity building and aligning with other related sectorial support (e.g. environment, housing)	World Bank funding varies significantly from year to year, depending on when large projects are approved (i.e. 2010 – $193.66, 2011 – $537.2, 2012 – $15).	
UNITAID	To increase "access to treatment for HIV/AIDS, TB and malaria for people in developing countries by leveraging price reductions of drugs and diagnostics, which currently are unaffordable for most developing countries, and to accelerate the pace at which they are made available."[10]	• **Funding/financing** • **Market dynamics** UNITAID provides funding aimed at market-based diagnostics and treatment interventions. It also focuses on drug-purchasing, with an emphasis on combatting multi-drug-resistant TB.	Funding projects to impact market for TB diagnostics & treatment products; emphasis on MDR TB	$26 (estimate)[11]	Low- and middle-income countries

[8] World Bank "Human Development" topic page: http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/0,,contentMDK:20266824~menuPK:538117~pagePK:146736~piPK:226340~theSitePK:258644,00.html

[10] UNITAID "Mission and Strategy" page: http://www.unitaid.eu/en/who/mission-and-strategy

[11] Estimate based on CEPA analysis of UNITAID's Annual Report 2013, p.97. The figure was derived by multiplying overall project grants during 2013 by the proportion of funding commitments at the end of 2013 dedicated to TB control.

Organisation	Mandate/ Objective	Activity focus	Area of focus	Funding in 2013, US$ m	Geographical focus
The Bill and Melinda Gates Foundation (BMGF)	"To accelerate the decline in tuberculosis incidence worldwide."[12]	• **Funding/financing** • **Advocacy** BMGF provides funding mainly to research and development focused on more effective drug regimens, new diagnostic tools, improved vaccines, innovative delivery approaches, and R&D advocacy.	Funding for R&D for TB drugs and diagnostics	$115[13] (this figure is for 2012, which is the latest year for which data is available)	Global
Technical assistance					
WHO Global TB Programme	"The WHO Global TB Programme aims to advance universal access to TB prevention, care and control, guide the global response to threats, and promote innovation"[14]	• **Technical assistance** • **Coordination** • **Advocacy** The WHO Global TB Programme describe their core functions as providing global leadership on matters critical to TB; developing evidence-based policies, strategies and standards; providing technical support to Member States; monitoring the global TB situation; shaping the TB research agenda; and facilitating and engaging in partnerships for TB action.	Multiple	N/A	Global
US Government – Centres for	"The mission of the Division of Tuberculosis Elimination (DTBE) is to promote health and quality of life by preventing, controlling, and eventually eliminating	• **Technical assistance** • **Funding/financing** The CDC is the lead agency for domestic TB prevention and care efforts, and provides	Multiple	N/A	United States / Global

[12] BMGF "Tuberculosis Strategy Overview" page: http://www.gatesfoundation.org/What-We-Do/Global-Health/Tuberculosis
[13] BMGF Annual Report 2012
[14] WHO "Global TB Programme" page: http://www.who.int/tb/about/en/

Organisation	Mandate/ Objective	Activity focus	Area of focus	Funding in 2013, US$ m	Geographical focus
Disease Control	tuberculosis from the United States, and by collaborating with other countries and international partners in controlling global tuberculosis."[15]	international technical support for global TB care and treatment in collaboration with USAID and OGAC. In many low and middle income countries CDC is a channel for USG funding for selected TB and TB/HIV control activities.			
The International Union against Tuberculosis and Lung Disease	"The Union brings innovation, expertise, solutions and support to address health challenges in low- and middle-income populations"[16]	• **Technical assistance** • **Research and development** The Union is an international scientific Institute specialising in technical assistance, operational research and education: addressing the challenges of tuberculosis, lung disease, HIV/AIDS and tobacco control in low and middle-income countries.	Multiple areas of focus, with an emphasis on operational support	$47[17]	Global
KNCV TB Foundation	"The global elimination of TB through the development and implementation of effective, efficient and sustainable TB control strategies"[18]	• **Technical assistance** • **Research and development** • **Coordination** The KNCV TB Foundation facilitates the exchange of knowledge and experience on tuberculosis control with countries and partner organizations; and provides support, advice and research.	Multiple	$52[19]	Global, but mainly Africa, Asia, Central Asia, and Europe.

[15] US Centre for Disease Control: http://www.cdc.gov/tb/about/mission.htm
[16] The Union "Mission, Vision, and Values" page: http://www.theunion.org/who-we-are/mission-vision-and-values
[17] The Union Annual Report 2013, p.35
[18] KNCV "Tuberculosis Control Worldwide" page: http://www.kncvtbc.org/tuberculosis-control-worldwide
[19] KNCV TB Foundation Annual Report 2013

Organisation	Mandate/ Objective	Activity focus	Area of focus	Funding in 2013, US$ m	Geographical focus
Tuberculosis Technical Assistance Mechanism (TB TEAM)	"To improve Global Fund TB grant performance and relieve bottlenecks to grant-implementation by linking countries with quality technical assistance"[20]	• **Technical assistance** TBTEAM, with a secretariat housed in WHO, is the Global coordination mechanism for technical assistance in TB. Its primary role is to coordinate between other technical assistance organisations. It supports Global Fund grants by linking partners to countries for proposal preparation; grant negotiation; implementation of grants; consolidation of plans across multiple grants; provision of technical assistance to address grant bottlenecks; and on-going grant monitoring. TB TEAM also collects and shares information on technical assistance missions.	Technical assistance in support of Global Fund TB grants	N/A	Global
TBCTA (Tuberculosis Coalition for Technical Assistance), 2000-05 **/ TB CAP (Tuberculosis Control Assistance Program)**, 2005-10 / **TB CARE**, 2010-15 / **Challenge TB**, 2014-19.	To implement USAID's global anti-TB strategies.	• **Technical assistance** The time-limited 5-year mechanisms TBCTA, TB CAP, TB CARE, and Challenge TB are all coalitions of TB technical assistance organisations funded by USAID to support and implement successive anti-TB strategies. KNCV was lead partner for each coalition. The coalition supporting Challenge TB will include the American Thoracic Society (ATS), FHI 360, International Union Against Tuberculosis and Lung Disease (The Union), Japan Anti-Tuberculosis Association (JATA), KNCV Tuberculosis Foundation (KNCV), Management Sciences for Health (MSH),	Broad technical assistance	N/A (USAID will invest US$525m in Challenge TB over its five-year duration[21])	Global

[20] TB TEAM "About TB TEAM" page: "http://www.who.int/tb/tbteam/aboutus/en/"
[21] TB CARE I homepage: "http://www.tbcare1.org/"

Organisation	Mandate/ Objective	Activity focus	Area of focus	Funding in 2013, US$ m	Geographical focus
		WHO, PATH, and Interactive Research and Development (IRD).			
Research and development					
US Government – National Institutes of Health (NIH)	"The National Institute of Allergy and Infectious Diseases (NIAID) supports research to improve TB diagnosis, control, and prevention."[22]	• **Research and development** The NIH leads USG research efforts for the development of new TB diagnostics, drugs, and vaccines. The **National Institute of Allergy and Infectious Diseases** (NIAID) is the lead institute for TB research within the NIH. NIAID supports research in the following areas to improve TB diagnosis, control, and prevention: (i) basic TB research; (ii) TB prevention and vaccine development; (iii) TB diagnostic research; (iv) advances in TB treatment; and (v) TB research training.	TB Research – R&D for drugs and diagnostics	N/A	United States / Global
The Global Alliance for TB Drug Development (TB Alliance)	"To discover and develop better, faster-acting, and affordable drugs to fight tuberculosis"[23]	• **Research and development** TB Alliance is a not-for-profit product development partnership to lead the search for new TB regimens and catalyse global efforts for new TB regimens.[24] Manages a portfolio of candidate TB compounds using licensing and partnership agreements.	TB Research – R&D for drugs	39.5[25] (this figure is for 2012, which is the latest year for which data is available)	Global
Advocacy					

[22] NIAID, http://www.niaid.nih.gov/topics/tuberculosis/research/pages/researchgoals.aspx
[23] TB Alliance "Our mission" page: http://www.tballiance.org/about/mission.php
[24] Ibid.
[25] TB Alliance 2012 Audited Financials, p.6 "Total Program Services"

Organisation	Mandate/ Objective	Activity focus	Area of focus	Funding in 2013, US$ m	Geographical focus
UNAIDS	The general UNAIDS strategy aims "to advance global progress in achieving country set targets for universal access to HIV prevention, treatment, care and support and to halt and reverse the spread of HIV and contribute to the achievement of the Millennium Development goals by 2015".[26] UNAIDS' TB-related goal is "to halve the number of tuberculosis-related deaths among people living with HIV to less than 250 000 in 2015"[27]	• **Advocacy** • **Coordination** • **Technical assistance** As a United Nations entity, UNAIDS exercises leadership in the global AIDS response and advocates for people vulnerable to and affected by HIV.	HIV/TB prevention, treatment, care and support.	N/A	Global
Global Coalition of TB Activists (GCTA)	"To be an advocacy platform and effectively represent TB affected communities in order to influence global TB control agenda through patient empowerment, strategic advocacy and community mobilization"[28]	• **Advocacy** GCTA's comparative advantage lies in advocacy, activism, and representation of communities affected by TB.	TB-affected communities	N/A	Global

Source: CEPA analysis of public websites and publications

[26] UNAIDS Strategy 2011-15, p.7
[27] UNAIDS Global Report 2013, p.60
[28] GCTA "Vision and Mission" page: http://www.gctacommunity.org/index.php/visionandmission

ANNEX 5 REVIEW OF PARTNERSHIP ACTIVITIES AND RESULTS FROM ANNUAL REPORTS

This annex presents a mapping of the Partnership's activities and results, based on the information included in the Annual Reports for the period 2007-13. It is important to note that this mapping is not a comprehensive representation of all the Partnership activities and results, but is only based on what is reported in the Annual Reports.

As per our analysis in the main report, we have categorised the Partnership's activities into four areas of focus:

- Advocacy and communications;
- Partnerships;
- TB REACH; and
- GDF.

The main points from our review of the activities and results presented below are as follows:

- *There are a range of activities undertaken under the advocacy and communications area of work, with a lack of overall strategy.* While a number of important activities are highlighted, there is a lack of a defining/ coordinating purpose for the various activities. To a certain extent, this appears to have improved from 2012 onwards; since then advocacy and communications activities have been centred on a small number of areas (such as Global Fund engagement, BRICS, and TB and mining).
- *Partnership-building work over 2007-12 has mainly focused on developing the partner base and working with national partners, with no information on the results of these activities.* Although working with national partners was de-prioritised in 2013, overall, there is very limited reporting on the results of partnership activities.
- *TB REACH and GDF report more outcome-level results, given the more downstream nature of their activities.* Their results relate more to outcomes, rather than outputs, which is important to support the linkages with the Global Plan targets (for example, in terms of number of additional cases detected or number of patient treatments provided).
- *Overall, the focus of the reporting is on activities rather than results*, with limited follow-up of activities between annual reports. However, there has been a greater emphasis on results-based reporting since 2012, as well as better linking between years.

Table A5.1: Reporting of activities and results in the Stop TB Partnership Annual Reports

Area of focus	Activity	Results
Advocacy and Communications		
2007	Conferences and Events:: • To mark World TB Day, the Partnership supported a European Centre for Disease Prevention and Control symposium at the European Parliament, which was attended by more than 100 policy-makers. The Secretariat supported a scientific meeting at the Robert Koch Institute with the German Minister of Health to mark the 125th anniversary of the discovery of the TB bacillus. • In May, the Executive Secretary of the Stop TB Partnership was a speaker at the annual Global Health Council conference, at which he released a report on the latest GDF accomplishments. • In July, a bipartisan, bicameral briefing was held in partnership with the Global Health Council, RESULTS Educational Fund and the American Thoracic Society to review the Global MDR-TB and XDR-TB Response Plan and the role of US government agencies in strengthening the basic elements of global TB control. • A briefing was held at the Norwegian Parliament on the subject of vaccine development by the Chair and Secretariat of the New Vaccines Working Group. • The Secretariat worked with US partners to intensify advocacy efforts, principally through leveraging high profile events in Washington DC to raise awareness of TB. Publications & website: • 'TB Returns to Europe', an op-ed piece signed by Executive Secretary Dr Marcos Espinal highlighting the need for European solidarity in fighting TB, appeared in the Wall Street Journal Europe in March. • The Stop TB Partnership website was revamped to include more frequent and livelier news stories, features and photos. The Stop TB website received 2,055,000 visits during the course of the year – a 39% increase over 2006. Celebrity engagement: • Dr Sampaio - UN Secretary-General's Special Envoy to Stop TB - addressed the European Parliament Development Committee in April and called for EU-Africa Action plans to mirror the domestic TB Action Plan for the EU. • Anna Cataldi, who served as a UN Messenger of Peace from 1998 to 2007, was appointed a Stop TB Ambassador. Ms Cataldi's mandate is to raise global awareness about the heavy burden of TB on refugees, migrants, people living in poverty and other disadvantaged groups. In June, Ms Cataldi visited Afghanistan at the invitation of the WHO Regional Office for the Eastern Mediterranean. Her aim was to build further political commitment and support for TB control from the Afghan authorities and partners, including donor countries	Conferences and Events: • In October, the UN Secretary-General's Special Envoy to Stop TB spoke at a Centre for Strategic and International Studies policy event alongside US Senator Sherrod Brown and US Global AIDS Coordinator Mark Dybul. As this event was held at the same time as important US budget deliberations, Dr Sampaio discussed appropriations with several Members of Congress. These efforts, combined with the hard work of Stop TB partners, saw US commitments spending for global TB control double for the 2008 financial year, in addition to an increase in funding from the US President's Emergency Plan for AIDS Relief to address the TB/HIV co-epidemic.

Area of focus	Activity	Results
	and NGOs working in the field. In November, at the opening ceremony of the 38th Union World Conference on Lung Health, she announced the slogan for the 2008-2009 World TB Day campaign: I AM STOPPING TB. Other advocacy activities: • The Stop TB Partnership embarked on an exciting new advocacy project that seeks to raise awareness about TB through music. The project draws on long-standing links between TB and opera – in particular, the operas La Traviata (Verdi) and La Bohème (Puccini), whose narratives both focus on the tragic death of a young woman from TB. The project will also raise awareness of TB through the performance of music by Chopin, Boccherini, Pergolesi and other composers who lost their lives to the disease. At a benefit concert on Sunday 25 March at the Black Diamond Theatre in Copenhagen, soprano Elsebeth Dreisig and tenor Niels Jørgen Riis sang arias from La Traviata, and celebrated pianist Leif Ove Andsnes played Frédéric Chopin. Proceeds from the concert were donated towards the repair and reopening of the children's TB hospital in Dushanbe, Tajikistan. • A team of eight HDNet correspondents from India, the Philippines, Thailand, Uganda, Zambia and Zimbabwe covered the Union World Conference in Cape Town, South Africa in November, thanks to sponsorship by the Stop TB Partnership. • The staff of the Partnership Secretariat lit up the windows of WHO headquarters with the words STOP TB to raise public awareness of the disease.	
2008	Publications & website: • The Stop TB Partnership web site continued to draw a broad worldwide audience. There were 4,179,833 views of the site in 2008 – a 13% increase over 2007. Celebrity engagement: • Stop TB Ambassadors: • High level visit to Afghanistan and Pakistan by Stop TB Ambassador Anna Cataldi • Luis Figo appointed as Stop TB Ambassador Other advocacy activities: • In 2008, the Stop TB Partnership engaged in a concerted campaign to raise public awareness about (and political commitment to stop) the HIV/TB pandemic.	Engagement with the Global Fund: • As an outcome of its Eighteenth Board Meeting in New Delhi, India, the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria agreed on a decision point (number 12) aimed at massive scale-up of the actions needed to fully implement the Stop TB Strategy and the Global Plan to Stop TB. The Board considered this decision point after a call from the Stop TB Partnership.
2009	Engagement with the Global Fund: • In February 2009, Dr Marcos Espinal, Executive Secretary of the Stop TB Partnership, and Dr Michel Kazatchkine, Executive Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria, signed a memorandum of understanding regarding cooperation between the two organizations	

Area of focus	Activity	Results
	Publications & website: • The Treatment Action Group (TAG) and the Stop TB Partnership released a report in December 2009 showing that lack of funding is the main obstacle to progress in developing a highly sensitive and quick blood or urine test for active TB, new TB drugs and an effective TB vaccine. • The Partnership Secretariat launched a ground-breaking blog, www.worldtbday.org, where partners around the world announced news, reports on events, and shared posters, photos, videos and other materials relating to the "I am stopping TB" campaign. • The Stop TB Partnership website, www.stoptb.org, continued to draw a broad worldwide audience. There were 4,804,386 views of the site and 2,061,989 visits in 2009. Celebrity engagement: • Stop TB ambassadors • In February, Stop TB launched a public-service announcement in which Figo observes a moment of silence for the thousands of people who die each day of TB. • In June, the Partnership launched an animated version of the Stop TB Partnership's 2008 comic book, Luís Figo and the World Tuberculosis Cup, which was broadcast to satellite television viewers in 80 countries. • Ms Cataldi attended the launch of the Stop TB National Partnership Morocco in October Other advocacy activities: • A Partnership delegation paid a high-level visit to South Africa in July 2009, greeted by Deputy President Kgalema Motlanthe, and meeting at length with Health Minister Dr Aaron Motsoaledi, with whom they discussed the findings of the recent TB programme review led by WHO and several partners.	
2010	Conferences and Events: • In July, the Stop TB Partnership had a strong presence at the International AIDS Conference • Top multinational business and non-profit-making leaders met in New York on 23 March to discuss the role of the private sector in curbing the spread of TB. • In 2010 Dr Jorge Sampaio engaged in political advocacy on high-level missions and at events. • In 2010 the Stop TB Partnership Secretariat launched a new 2-year campaign - On the Move Against Tuberculosis - built on the theme of innovation. Publications & website: • Development and launch of a new roadmap for the Partnership – the Global Plan to Stop TB 2011 – 2015: Transforming the Fight Towards Elimination of Tuberculosis.	

Area of focus	Activity	Results
	• The Stop TB Partnership website, www.stoptb.org, drew an unprecedented audience in 2010, with nearly 8 million visits – a 36% increase over 2009. • The Stop TB Partnership Flickr site received over 16,000 views between its creation in March 2010 and 1 January 2011; in the same timeframe, the newly established Stop TB Partnership YouTube channel had 27,560 upload views. Celebrity engagement: • Ambassadors included Craig David, Anna Cataldi, and Luis Figo. Other advocacy activities: • In 2010, efforts focussed on high-level advocacy to secure political leadership and commitment on TB, increasing the impact of Stop TB Partnership Coordinating Board meetings and introducing a stronger role for the private sector.	
2011	Engagement with the Global Fund: • In 2011, the Stop TB Partnership increased its engagement with the Global Fund, which provides about 80% of the external funding for TB care. From the second half of 2011, the Executive Secretary of the Stop TB Partnership represented the Partners Constituency (which consists of Roll Back Malaria and UNITAID as well as the Stop TB Partnership) on the Global Fund Board. The Stop TB Partnership also served as the communications focal point for the constituency and had as its task the alignment of the positions of the three organizations. In an unprecedented move, the Stop TB Partnership organized a TB Session for Board Members at the 25th Global Fund Board Meeting held in Ghana in November 2011. The Stop TB Partnership was also well represented on the Board committees and technical bodies of the Global Fund • Dr Ditiu was part of the Strategy Working Group that led the development of the Global Fund Strategy 2012–2016. • India - Secretariat staff travelled to India to review and provide assistance to Project Axshya. This is one of the largest Global Fund-financed projects focusing on community involvement and ACSM, targeting more than 750 million people. Conferences and Events: • In April the health ministers of Lesotho, South Africa and Swaziland joined the Stop TB Partnership's Executive Secretary and the Chair and Vice-Chair of the Stop TB Partnership Board on a mission to Washington D.C. to spur policy-makers to ramp up their support for the fight against TB. • The Partnership launched Time to act: Save a million lives by 2015, at an event during the UN High-Level Meeting on AIDS in June. Hosted by Ray Chambers, the UN Secretary General's Special Envoy for Malaria and MDG Advocate, the event featured pledges from Michel Sidibé, Executive Director of UNAIDS; Michel Kazatchkine, Executive Director of the	Engagement with the Global Fund: • The strong engagement of the Stop TB Partnership in the Global Fund ensured that Global Fund policies are TB-friendly. The Global Fund Strategy 2012–2016 has bold TB targets consistent with the Global Plan to Stop TB, and TBTEAM is more aligned than ever before in working closely with the Global Fund secretariat.

Area of focus	Activity	Results
	Global Fund; and Eric Goosby, US Global AIDS Coordinator to work with the Stop TB Partnership to save a million lives by 2015. Together with UNITAID, the Stop TB Partnership reinforced this call at an Every Woman, Every Child event on maternal and child health in September, convened by Ray Chambers. • With MDR-TB and XDR-TB spreading at an alarming rate across the European continent WHO's Regional Office for Europe has developed an ambitious plan to arrest the pandemic in its tracks. The "Consolidated action plan to prevent and combat multidrug- and extensively drug-resistant tuberculosis in the WHO European region 2011-2015"—which sets out to prevent 263,000 cases of MDR-TB and XDR-TB and 120,000 deaths from the two conditions—was launched in Baku, Azerbaijan in September. A parallel press event in London was organized and supported by the Stop TB Partnership Secretariat. Publications & website: • On the occasion of World TB Day, the Stop TB Partnership Secretariat and IFRC jointly released "Towards a tuberculosis-free world", a report offering a window on the human side of the global TB pandemic and efforts to reach the unreached millions of people affected by TB. Celebrity engagement: • The Stop TB Partnership worked with two Goodwill Ambassadors to raise awareness about TB among broad audiences: football legend Luis Figo and British pop star Craig David. Other advocacy activities: • The Stop TB Partnership, with WHO and UNAIDS, produced a model which could pave the way to dramatic progress in the fight against the TB and HIV co-epidemic. The model shows that by scaling up activities that are already in place, more than a million lives could be saved by 2015 at a cost of around US $400 per person a year. • Dr Ditiu, the Stop TB Partnership's Executive Secretary, appeared on BBC World and Al Jazeera news; and was featured on BBC's morning radio programme, which reaches millions of people all over the globe. • In December, the Stop TB Partnership Secretariat and the International Federation of Red Cross and Red Crescent Societies hosted, held a meeting in Geneva of nine celebrities who are lending their images and voices to the fight against TB in Georgia, Ghana, Jordan, Nepal, Pakistan, Peru, South Africa and Sudan. These actors, film-makers and media stars are helping to frame an initiative aimed at enhancing the impact of national TB ambassadors. • Cambodia - Secretariat staff helped develop an advocacy, communications and social mobilization (ACSM) plan that aims to increase awareness about TB, improve access to diagnosis and treatment and address TB among migrants, the elderly and disadvantaged groups.	

Area of focus	Activity	Results
2012	Engagement with the Global Fund: • The Partnership Secretariat worked very closely with the Strategy Committee (SIIC) of the Global Fund, and even though the Partnership is not a member of the committee the Partnership Secretariat it worked through TB supporters in SIIC to brief and interact with them to provide the best advice and information. • The Partnership Secretariat worked hard, together with colleagues from WHO to contribute in developing various elements of the new funding model – disease score and country funding envelopes, strategic investment framework, funding bands - ensuring that TB perspective was heard. Many partners came together around the Global Fund to voice concern over the proposed funding model for decision at the Global Fund Board meeting in September. A document was prepared to represent the reaction of the TB Community represented by the WHO Stop TB department and the Stop TB Partnership. This was circulated to partners, many of whom signed in support of the position. • The Partnership Secretariat engaged into a unique approach for collaboration with the Communities constituency at the Global Fund, and signed an agreement for joint work in support of TB advocacy among the members of the Global Fund Board and their constituencies. The interaction with the Secretariat of the Global Fund is much strengthened – also because of a better approach of the Global Fund Secretariat to the work with partners - and the Partnership Secretariat has very recently established clear working relationships with the CCM and Advocacy teams of Global Fund. • The informal Global Fund TB Friends platform increased in the number of partners, and is expected to move to a different level by formalizing and developing it in a more rigorous manner as part of the Secretariat's operational strategy. Activities in Kuala Lumpur during the Union meeting and the Stop TB Board represented the best example of the efforts to increase the visibility around TB. Having the Health Minister Xaba of Swaziland in our Global Fund constituency seat and having him championing over strategic objectives ensured that the TB voice was heard loud and clear. Conferences and Events: • 2012 saw important breakthroughs in TB advocacy. Regional political fora, first and foremost the Southern African Development Community (SADC) and BRICS countries, showed strong leadership and initiative on TB, providing impetus to global discussions and resource mobilization activities for TB. • On World TB Day 2012, WHO and the Stop TB Partnership made a global call to address this hidden epidemic. In an advocacy brochure - No more crying, no more dying - the organizations said that, with better training and harmonization of the different programmes that provide health services for children, serious illness and death from TB could be prevented in thousands of children every year.	Engagement with the Global Fund: • In 2012, the Stop TB Partnership Secretariat engaged in unprecedented efforts around advocacy for and with the Global Fund. The Partnership is represented in the Global Fund Board, Phase 2 panels and TB Diseases committees of the Global Fund. Through our representation on the Global Fund phase 2 panel since 2012, between Wave 5 and 10 of second phase grant renewals the following were collectively achieved: • Additional funds (over and above what CCM had asked) were approved for Bangladesh – 10 million USD additional for expanding case finding and new diagnostics through civil society PR in order to promote greater impact of the grant. This was unprecedented in TB grants in second phase. • Additional funds earmarked for TB/HIV in the HIV grant of Nigeria and TB grant of Nigeria re-programmed towards higher impact scale up of MDR-TB and PPM services. • Advocacy efforts resulted in both TB and HIV grants being discussed together in one session. The issues raised in this meeting resulted in the Global Fund Secretariat referring to a joint TB/HIV disease. • DPR Korea, Tajikistan and Lesotho re-programmed grants were supported with inclusion of new diagnostics and MDR-TB scale up. • In Wave 11, a new approach for Pakistan was attempted to top-up the grant to achieve full coverage, including Public-Private Mix, case finding intervention and massive Programmatic Management of Drug-resistant TB scale up. Direct engagement with countries: • On 18 August the fifteen SADC Heads of State signed a Declaration on TB in the Mining Sector, committing them to address the raging TB epidemic among current and ex-mine workers, their families and affected communities. Three members of the Stop TB Partnership Coordinating Board have been the driving force behind the initiative that led to the Declaration: Dr Aaron Motsoaledi, Minister of Health of South Africa; Dr Mphu Ramatlapeng, Vice-Chair of the Global Fund Board and former Minister of Health of Lesotho; and Mr Benedict Xaba, Minister of Health of Swaziland. The Stop TB Partnership has played a coordinating role, fostering multi-lateral collaborations with the World Bank and International Organization for Migration in order to ensure the implementation of the Declaration.

Area of focus	Activity	Results
	Celebrity engagement: • In November, the Stop TB Partnership launched a guide to working with national celebrities. The handbook, a practical guide to collaborative partnerships with celebrities, co-produced with the International Federation of Red Cross and Red Crescent Societies, provides Stop TB Partners with guidance on how to engage celebrities and benefit from their support. The targeted audience is mainly public health professionals who would like to expand their knowledge for engaging celebrities and managing high profile events. The objective is to share the experience gained while working with current champions against TB.	• In 2012, BRICS health ministers developed a pact to enhance their cooperation on drug-resistant TB, to be formalized in a pact in 2013. All five BRICS countries are represented at ministerial level at the Stop TB Partnership Coordinating Board and exchange of views take place on a regular basis. The Partnership Secretariat will continue to work with its ministerial champions from the BRICS countries in order to support their cooperation on drug-resistant TB.
2013	Engagement with the Global Fund: • In addition to supporting Global Fund advocacy efforts, the Secretariat engaged heavily with the Global Fund Board, committees and secretariat on policy, strategy and financing decisions to leverage additional TB resources for countries. • The Secretariat engaged also in technical aspects of Global Fund grants through its participation in the Grant Approval Committee, TB Disease Committee and Global Fund TB-HIV Working Group. • In the last quarter of 2013, the Secretariat worked intensively with the Global Fund, WHO, UNAIDS and RBM to put forward the content for the newly established Technical Assistance agreements between the Global Fund and these partners. Conferences and Events: • In February, WHO and the Secretariat convened a workshop that proposed a set of goals and targets to guide the global fight against TB post-2015. Thirty-one experts including representatives from TB high burden countries, development and technical agencies and research and development entities, advocates from civil society, epidemiologists and experts on modelling participated in the meeting. • At the World Conference on Lung Health in Paris, the Secretariat organized a preparatory BRICS meeting on TB and HIV in support of the BRICS health ministers meeting in November 2013. • Planning for World TB Day 2014 - The Secretariat organized three advocacy meetings and a workshop to coordinate planning and messaging among partners and to discuss messaging. • The Secretariat supported community representatives from Africa to attend the International Conference on AIDS and STIs in Africa (ICASA) where they organized training TB/HIV as a pre-conference activity and designed overalls that were half TB and half HIV. These were used by conference attendees to raise awareness of the co-infection. During	Engagement with the Global Fund: • The Global Fund continued to be a key focus for both the Secretariat and its partners. In the run up to the fourth replenishment conference, donors pledged US $ 12 billion, the largest amount ever committed to the fight against AIDS, TB and malaria. This would not have happened without the high level political advocacy and grassroots support cultivated by partners. The Secretariat accompanied the Global Fund in all the significant moments along the replenishment path, supporting through advocacy messages, providing input to documents and communications and participating in the replenishment conference as well as round table sessions such as those organized by the Global Fund Friends in Europe and Africa. • In addition to policy work, the Secretariat worked heavily to enhance civil society representation at country level through Country Coordinating Mechanisms. Three civil society organizations from Cameroon, Nigeria and Uganda have been directly supported to receive funding from GIZ totalling more than US $400,000 to do work around the Global Fund in their countries from 2013-2015. The Secretariat also supported two networks of TB advocates which successfully applied for more than US $300,000 of GIZ funding for Global Fund work and networking among TB groups. • The Secretariat was instrumental in the development of the Global Fund 'Situation Room' designed to increase the disbursement of funds allocated for TB projects. Since mid-November 2013, Situation Room members – Global Fund, TB CARE, USAID, TB TEAM Secretariat and the Stop TB Partnership Secretariat – have held regular meetings and discussed a number of country-specific issues on disbursement. The TB Situation Room's early warning system, intelligence sharing, and rapid

Area of focus	Activity	Results
	the conference, TB advocates also organized a session to inform delegates about the New Funding Model of the Global Fund. • In July in Nairobi, the Secretariat organized a meeting together with the TB Advocacy Consortium from Kenya with the aim to disseminate the mapping of civil society organizations working in TB, and strategize on how to build regional TB networks. • Forty community representatives and civil society members were supported to attend the International Union Conference in November. The Secretariat organized a session on TB and human rights where the importance of including human rights activities into TB programmes in Global Fund proposals was highlighted. • Ten African civil society actors were supported together with GIZ to attend the African Regional Union Conference that occurs bi-annually. This was the first time that the Secretariat supported civil society at a regional conference. Publications & website: • The Secretariat developed topic-specific fact sheets and policy briefs on a range of issues. These not only facilitated discussions with key actors, but also significantly contributed to placing TB higher on political agendas. The Secretariat developed a fact sheet on 'TB in the Islamic countries' for the Organization of Islamic Cooperation (OIC) which was distributed at the heads of state summit in Cairo in January. • The Secretariat supported and worked with Treatment Action Group (TAG) to launch the 2013 Report on Tuberculosis Research Funding Trends.	deployment of targeted support has seen improved prioritization of critical funding for TB. Publications & website: • A policy brief on TB in Africa was developed by the Secretariat for the Abuja+12 Summit in Abuja, Nigeria in July. The Executive Secretary addressed heads of governments and their representatives from all of the 54 African Union states. The Secretariat and partners provided technical and advocacy support to specific sessions of the Summit, which led to African leaders renewing their commitments to fighting AIDS, TB and malaria and undertaking to scale up actions aimed at eliminating the three epidemics as part of an overall goal to eliminate extreme poverty by 2030.
Partnerships		
2007	Global/ national partnership-building: • Supporting national and regional partnerships. Challenge Facility for Civil Society • In recognition of civil society's vital importance, we launched the Challenge Facility for Civil Society (CFCS), which provides financial support to grass-roots civil society organizations that are engaged in advocacy and social mobilization activities and are seeking to raise awareness and shape policymaking for tuberculosis, HIV/TB and drug-resistant tuberculosis.	Global partnership-building: • By the end of the year, the Partnership had 72 new members, for a total of 589 partners worldwide. • Eastern Mediterranean Region Partnership - In recognition of the growing need for wider partnership to address the threat of TB, the WHO Regional Office, together with the countries of the region, laid the groundwork for the formation of an Eastern Mediterranean Stop TB partnership, including development of plans for a launch in Cairo in May 2008. National partnership-building: • Stop TB Ghana was launched in March on the occasion of World TB Day. • Stop TB Japan was launched in November. Challenge Facility for Civil Society • In 2007, CFCS provided US$ 384,000 to 22 NGOs in 15 countries.

Area of focus	Activity	Results
2008	Global partnership-building: • In April, at a session at the United Nations Permanent Forum on Indigenous Issues, participants called for the development of a specific initiative on TB, led by indigenous peoples, to collaborate with the Stop TB Partnership. Then in November, for the first time, at a meeting in Toronto co-hosted by the Assembly of First Nations and the Inuit Tapiriit Kanatami, public health experts and leaders of indigenous peoples from 60 countries began to address TB among indigenous people worldwide. Challenge Facility for Civil Society • The Challenge Facility for Civil Society awarded its second round of grants in 2008. An independent review committee selected 23 civil society organizations in Bangladesh, Brazil, Cambodia, Cameroon, China, Ecuador, Ethiopia, Georgia, Ghana, Kenya, India, Indonesia, Nigeria, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe to receive a total of US$ 423,084.	Global partnership-building: • Stop TB reached a total of 917 Partners by the end of 2008.
2009	Global partnership-building: • The 3rd Stop TB Partners' Forum—the 'general assembly' of the Stop TB Partnership—took place in Rio de Janeiro, Brazil, from 23 to 25 March 2009, with more than 1200 participants from nearly 70 countries. Challenge Facility for Civil Society • In 2009, an internal review of the first two rounds of the CFCS, to assess and improve the performance of the grant-giving mechanism, was presented to the Stop TB Coordinating Board.	Global partnership-building: • The Stop TB Partnership reached a total of 1,191 partners by the end of 2009, an increase of 30% over the previous year. National partnership-building: • Six national partnerships were launched—in Afghanistan, the Dominican Republic, Morocco, Nigeria, Swaziland and Syria—for a total of 32 partnering initiatives in all six WHO regions and half of the TB high-burden countries.
2010	Global partnership-building: • In 2010 the Stop TB Partnership began analysis work to better understand its partners. National partnership-building: • The Partnership also provided technical assistance, both in country and by correspondence, to Kenya, Nigeria, Swaziland and India. Challenge Facility for Civil Society • In 2010, CFCS awarded a third round of grants worth between US$ 5,000 and US$ 20,000 to 22 civil society organizations in 16 countries.	
2011	National partnership-building: • In 2011 the Secretariat launched a new section of the web site—National Stop TB Partnerships in Action—that highlights the latest information on national partnerships' activities and future plans. There were 25 national partnerships featured on the website at the end of 2011.	Challenge Facility for Civil Society • In 2011, 22 organizations—which together had received $US 350,000 in CFCS's third round—reported their results. Through the projects 53,834 people acquired potentially life-saving knowledge about TB. Some of those people were reached directly by grantees; others were reached through individuals or other organizations the grantees had trained. The activities were wide-ranging — everything from street theatre performances to lectures by doctors to poster campaigns.

Area of focus	Activity	Results
	• The National TB Programme of Uganda asked the Secretariat to assess the status and operations of the Uganda Stop TB Partnership and help develop a shared action plan for its partners. • The Viet Nam Stop TB Partnership, with assistance from the Stop TB Partnership Secretariat in Geneva, has developed an innovative approach to increase care-seeking behaviour among people affected by TB. Challenge Facility for Civil Society • In February, the CFCS awarded its fourth round of grants to 21 organizations from Africa, Asia, Eastern Europe and Latin America.	• As a result of these community-level activities, 3,000 people were referred for a TB test, of whom 1,400 tested positive for TB disease and accessed life-saving TB treatment. In addition, the grantees found 1,000 people who had stopped taking their TB drugs and helped them to continue treatment.
2012	National partnership-building: • In 2012, the Secretariat continued to work with partners to help them develop national partnerships. These voluntary alliances draw on the skills and competencies of partners to increase efficiency, avoid duplication of effort and extend the reach of TB services. • In November, the Korea Stop TB Partnership and the Stop TB Partnership co-hosted the first ever Regional Forum of National Partnerships to Stop TB in the WHO Western Pacific and South-East Asia Regions in Seoul, Republic of Korea. Representatives from NGOs, national TB programmes, communities and the private sector met to share best practices, discuss common challenges and develop country-specific and regional plans of action to strengthen efforts to stop TB. • At the request of the national TB programme manager, the Stop TB Partnership Secretariat visited Nigeria in April to assist the national partnership in the development of a joint action plan to support the national strategic plan for TB control. The Secretariat helped the national partnership carry out a mapping exercise to identify the core competences, resources and reach of each partner. Challenge Facility for Civil Society • The CFCS launched a fifth call for proposals on 1 August 2012 and received 380 applications. The 11 grantees for this fifth round were announced in December.	National partnership-building: • In January, the Stop TB Partnership Secretariat brought together representatives from Thailand's national TB programme and NGOs to discuss challenges in delivering TB care in the country. They resolved to address a critical issue: the provision of healthcare to migrants from neighbouring countries who do not have access to the country's health insurance schemes. The NGOs, supported by the Global Fund, started to fill the gap in TB diagnosis and treatment provision, winning the support of community leaders from the migrant populations. External financing is now due to end but the national TB programme and NGOs plan to continue their collaboration through the national partnership. Global partnership-building: • In 2012, the Stop TB Partnership Secretariat carried out a biannual update of its directory of partners. When the project was completed in December there were a total of 953 active partners with a complete profile in the directory Challenge Facility for Civil Society Summary of fourth-round results: • Beneficiaries reached: 81 589 • Trainings/sensitization meetings organized: 299 • Community volunteers trained: 378 • TB and former-TB patients engaged and empowered: 309 • Information packs distributed: 102 465 • People reached through media programming: 324 184 • People screened for TB: 3262 • People referred for TB testing: 15 013

Area of focus	Activity	Results
2013	Global partnership-building: • New webpages were created to feature the work of partners and promote their work. The new pages are designed to help partners know how to best benefit from their membership in the Partnership as well as providing information on who the Secretariat's partners are. The Secretariat also highlights partners' activities through the newsletter and in the 'News from our Partners' section of the website. • In order to promote communication with partners, the Secretariat organized a meeting of partners – New opportunities for funding and engagement: Your role in the future of the Stop TB Partnership during the World Conference on Lung Health on 31 October 2013. The one-day meeting was attended by more than 100 participants, and it provided an opportunity to discuss the changes that have taken place following the approval of the Stop TB Partnership Secretariat's Operational Strategy 2013-2015 and governance reforms. • For the first time ever, the Secretariat also carried out an annual survey of partners to evaluate the level of satisfaction of the Secretariat's work among partners. Thirty per cent of partners responded and a large majority of these – 73% - said that they were either 'completely' satisfied or 'satisfied' with the Secretariat's work. An overwhelming 96% of respondents said that the work of the Secretariat was either 'very important' or 'extremely important' in the fight against TB. National partnership-building: • A publication Partnering and Public Health Practice - Experience of national TB partnerships was released based on activities and approaches taken by partners and national TB partnerships to support the work of national TB programmes and partners. Challenge Facility for Civil Society • The 6th call for proposals in December 2013 requested that applications focus on work around Country Coordinating Mechanisms, Community System Strengthening, and the New Funding Model Country Dialogue among other processes.	Global partnership-building: • In 2013, a total of 1,079 organizations were registered in the Directory of Stop TB Partners. • Secretariat supported and facilitated discussions on how to take the work of the Community Task Force (CTF) to a new level. In February 2013, CTF members and other TB activists met in Geneva facilitated by the Secretariat and agreed to evolve the community Task Force into a new global structure: the Global Coalition of TB Activists (GCTA). The Coalition was launched on World TB Day 2013. Challenge Facility for Civil Society • In Round 5, the CFCS awarded 11 grants. Grantees used this funding for varied purposes and the essence of the diverse activities can be captured in the following themes: mobilizing youth, establishing and strengthening networks, policy change and political commitment, and serving high risk groups.
TB REACH		
2009	• Resource mobilization efforts got a substantial boost during the year when a new initiative designed and developed by the Stop TB Partnership, TB REACH, was accepted for funding by the Canadian International Development Agency (CIDA). The total funding approved by CIDA for this initiative was CAN$ 120 million over a five-year period. Of this amount, CAN$ 19 million was received during 2009.	
2010	• The Stop TB Partnership launched the TB REACH initiative. • The Proposal Review Committee approved 30 projects in 19 countries for funding under Wave 1. The total amount committed through Wave 1 was US$ 18.4 million.	

Area of focus	Activity	Results
2011	• In February a call for a second wave of proposals was launched. Of the 318 proposals received 45 projects were approved. This second wave of projects will play a critical part in rolling out the Xpert MTB/RIF assay, a recently developed rapid diagnostic test that uses modern DNA technology.	• The first TB REACH wave of 30 projects (which were approved in 2010) began activities in 2011, and the results were impressive. In a target population of more than 65 million people, TB REACH projects increased case finding by 33% in a single year, reaching 80,000 people with active TB. In human terms, this translates into over 80,000 cases of infectious TB identified. During 2011, TB REACH projects saved an estimated 13,000 lives, and prevented almost 170,000 new infections. The average spent per capita of population covered per year was US$ 0.28. • In 2011 TB REACH procured more Xpert machines for use in multiple countries than any other single entity. • 30 wave 2 projects will implement Xpert, using 149 machines procured through the Stop TB Partnership's Global Drug Facility, and together they will perform 250,000 tests in the context of their projects.
2012	• TB REACH launched its third wave of funding in 2012, drawing 324 applications of which only 35 could be funded. This high demand, coupled with TB REACH's strong results, suggest that similar fast-track, high-performance programme models could be used to improve progress on other areas of TB where performance is lagging.	• TB REACH partners worked on 44 different projects in 29 countries, covering a population of 202 million people. They diagnosed 124,724 people with TB, 16% more than what was expected according to trends. Some projects delivered even more dramatic results, doubling case detection rates. Evaluation of the first wave of TB REACH projects showed that overall case detection increased by 33% and in some projects even doubled within a year. • In 2012, the TB REACH Secretariat, together with the WHO Stop TB Department, made a successful proposal to UNITAID for the scale up of the Xpert MTB/RIF rapid diagnostic test in 21 countries. The Executive Board of UNITAID approved funding of US$ 30 million to scale up access to Xpert MTB/RIF, and reduce the cost of its use. Under the grant, TB REACH supports partners in deploying Xpert machines and cartridges supplied by UNITAID. The grant triggered a reduction in the price of Xpert test cartridges from US $17 to less than US$ 10. The partnership with UNITAID will bring Xpert machines and tests worth a total of US $4.5 million to people in need. • The UNITAID partnership also supported TB REACH grantees in Pakistan, Bangladesh and Indonesia in developing sustainable business models for the delivery of Xpert testing in the private sector. Funding from TB REACH and UNITAID will provide nearly 500,000 Xpert tests and 75 machines to these three countries with the expectation that these projects will be self-sustaining after donor support has ended.

Area of focus	Activity	Results
2013	• The Wave 4 call for applications was launched in September 2013 and resulted in an unprecedented 1,067 registrations for Letters of Intent (LOIs).	
GDF		
2007	• During the course of the year GDF brokered technical assistance missions by drug management and TB experts to 57 countries. Drawn from members of the Stop TB Partnership, mission teams monitor the use of anti-TB drugs supplied by GDF and work with programmes to address bottlenecks and weaknesses in their sup- ply chain, calculate future drug needs and develop a procurement plan. • Through workshops in Costa Rica, Myanmar, the Philippines, Senegal and South Africa, GDF collaborated with partners to provide crucial training to national staff and regional consultants on how to better procure and manage anti-TB drugs. • GDF also worked with the WHO Prequalification Programme and pharmaceutical manufacturers to in- crease the global supply of quality-assured first- and second-line anti-TB drugs. • GDF further strengthened its procurement operations by expanding its second-line procurement team, signing long- term agreements with its procurement agents and concluding a competitive selection process among pre-qualified first-line drug manufacturers. • GDF also continued to develop its relationships with new donors, such as the innovative new financing mechanism UNITAID. • GDF, UNITAID and the Global Fund also signed an agreement to help increase access to and affordability of, quality-assured second-line anti-TB drugs for use in MDR-TB control.	• In 2007 the Global Drug Facility (GDF) delivered more than two million anti-TB treatments to 66 countries worldwide. • In 2007, GDF approved new grants of free anti-TB drugs for more than a million adults and children in 44 countries and placed drug orders on their behalf worth US$ 24.2 million. • In addition, 38 countries chose to procure anti-TB drugs through GDF using their own money or money from other donors, including 19 orders placed by recipients of grants from the Global Fund. GDF placed orders worth US$ 12.5 million for its Direct Procurement customers, of which US$ 8.2 million was paid by the Global Fund. Direct procurement continues to progress as a greater portion of GDF supply, increasing from 6.5% of GDF patient treatments supplied in 2003 to an all-time high of 47% in 2007 • GDF operations were audited in 2007 and re-certified as ISO 9001:2000 compliant for 'provision of quality-assured anti- TB drugs and related services to eligible national TB control programmes'. • UNITAID and GDF announced a new collaboration initiative to address life-threatening shortages of anti-TB drugs in 19 countries which already have confirmed future support from the Global Fund or another donor, but are unable to meet their immediate needs. • UNITAID funding will make it possible for GDF to procure and supply an estimated 4,716 patient treatments to MDR-TB programmes approved by the Green Light Committee in 17 countries by the end of 2011.
2008	• The Global Drug Facility performed 76 missions in 63 countries in all six WHO Regions in 2008 with the support of Stop TB Partners. • Through the operational streamlining of many processes, the Global Drug Facility continued to adhere to the business principles that comply with ISO 9001:2000 (a standard certification for quality management systems maintained by the International Organization for Standardization). • In December 2008, the Global Drug Facility received its recertification for ISO 9001:2000 and formed a subsection of its Business Advisory Committee dedicated to performing biannual management reviews that ensure regular monitoring of the effectiveness and efficiency of the Global Drug Facility services.	• In 2008, the Global Drug Facility delivered over 2.7 million anti-TB treatments to 69 countries worldwide, bringing the total number of patients treated through the Global Drug Facility to more than 13.9 million in 88 countries. • Through its direct procurement service, the Global Drug Facility placed 59 orders for 54 countries, worth US$ 12.8 million. • In 2008, 65 orders, totalling US$ 18.2 million, were delivered to 31 countries.

Area of focus	Activity	Results
	• In November, the Global Drug Facility and UNITAID signed an Agreement for the MDR-TB Acceleration of Access Initiative: Strategic Rotating Stockpile. This Agreement will allow for the establishment of a Strategic Rotating Stockpile: an increase of the current stockpile from 800 patient treatments worth of second-line drugs to 5800. • Also in 2008, UNITAID increased its financial commitment, from US$ 5.7 million to US$ 11.6 million, for the Global Drug Facility to procure and supply quality-assured paediatric drugs from 2007 to 2011. • In 2007, the Global Drug Facility added diagnostic equipment to its product catalogue. The year 2008 saw growth in this service area, with further growth anticipated for 2009. The diagnostic products include consumables kits, microscope kits, sputum containers and equipment starter kits.	• In 2008, 29 grant orders, with a value of US$ 3.0 million, were placed by 12 countries using funds provided by UNITAID. Also, 27 grant orders, valued at US$ 2.1 million, were delivered to 12 countries. • The Global Drug Facility placed 69 second-line medicine orders through its direct procurement service for 32 countries. These orders had a product value of US$ 15.4 million. In 2008, 68 orders, valued at US$ 9.9 million, were delivered to 30 countries.
2009	• In 2009, GDF performed 88 missions to 64 countries in all six WHO regions, an increase over the 76 missions undertaken in 2008. Of these 88 missions, one was a pre-delivery country visit, 42 were grant monitoring missions, 33 were direct procurement technical support missions and 12 were technical assistance missions. • GDF also held six workshops—in Bangladesh, Belarus, Brazil, Pakistan, Tunisia and Uganda— focusing on capacity building and drug management as well as the use of first- and second-line medicines.	• In 2009, the Global Drug Facility (GDF) delivered more than 2.4 million anti-TB treatments, bringing the total number of patients treated through GDF to more than 16.5 million. • In 2009, through GDF's grant services, 59 orders were placed by 18 countries. These orders had a total value of approximately US$ 18.2 million. Furthermore, shipments valued at an estimated US$ 30 million were delivered to 28 countries1. In 2009, 1 212 466 patient treatments were delivered through GDF's grant service • In 2009, 87 direct procurement orders were placed by 52 countries with a value of US$ 25 628 967, and GDF delivered shipments of adult first-line medicines to 57 countries3 with an all-inclusive value of US$ 26 599 905. The direct procurement mechanism delivered 867 848 patient treatments in 2009. • In 2009, 53 orders for paediatric 1st line drugs with a total value of US$ 2 846 172 were placed for 42 countries through GDF's grant service. GDF delivered paediatric medicines with an all-inclusive value of US$ 3 101 6824 to 45 countries. • In 2009, 373 960 curative and preventive paediatric anti-TB treatments were procured through GDF's grant service. • Grants of second-line anti-TB medicines: In 2009, 12 countries placed orders valued at US$ 4 203 670, and 13 countries7 received deliveries totalling US$ 5,688,264. • In 2009, 38 countries purchased anti-TB second line medicines through direct procurement,

Area of focus	Activity	Results
		• The Strategic Rotating Stockpile for MDR-TB drugs was fully operational and servicing orders in 2009; 39 countries used it during the year. • In 2009, 15 countries placed orders for diagnostic equipment worth US$ 1 291 809. Fifteen countries received deliveries of diagnostic kits in 2009 with a value totalling US $1,698,288.
2010	• GDF grant funding - 31 applications from 22 countries were approved; 46 countries from five regions placed grant orders for first-line drugs. • GDF restructuring - During 2010, the Stop TB Partnership Coordinating Board commissioned the Boston Consulting Group (BCG) to assess the future direction of GDF and provide an implementation and restructuring plan. • In July, GDF published its latest quality assurance policy.	• GDF Direct Procurement - GDF's procurement services business grew strongly in 2010. The total value of orders placed in 2010 was US$ 87 million, up from US$ 48 million in 2009. • Second line Drugs - Fourteen countries placed grant orders utilising funding from UNITAID pursuant to the MDR-TB • Scale-Up Project, and more than 12 000 MDR-TB patients were enrolled under GLC projects. • In 2010, a total of 52 monitoring missions were conducted in 52 countries.
2011		• In 2011, GDF procured 2,029,124 adult treatments for drug-sensitive TB (first-line treatments), 280,526 paediatric first-line treatments and 19,605 second-line patient treatments. • $136,454,469 - Value of goods procured • $40,622,616 - Value of adult first-line drugs procured • $3,928,781 - Value of paediatric FLDs procured • $77,706,424 - Value of SLDs procured • $935,099 - Value of consumables • $5,204,710 - Value of diagnostics procured for the Expand TB Project • $2,037,545 - Value of GeneXpert machines procured for TB REACH
2012	• In 2012, GDF continued to deliver its mandate to supply quality-assured anti-TB drugs for first and second line TB treatment as well as laboratory equipment to meet countries' needs, either in the form of grants or a the lowest price possible. • In 2012, joint meetings with the United States Pharmacopeia (USP) Promoting Quality of Medicines program (PQM) and the WHO Prequalification Program were held to encourage additional manufacturers to become prequalified.	• The total volume of goods procured totalled US $ 151 million in 2012, including US $58 million in first line drug treatments, US $74.5 million in second line drug treatments and US $18.5 million in diagnostics/laboratory equipment. These values include all costs associated with orders: goods, procurement agent fees, freight, quality control, pre-shipment inspection and insurance. • In 2012, GDF delivered 39 383 treatments for MDR-TB patients. This was double the number of MDR-TB treatments supplied in 2011 (see chart below). GDF also supplied 1 067 087 treatments for patients with drug-susceptible TB, including 162,000 treatments for children

Area of focus	Activity	Results
		• 2012 saw the scale-up of the Expand TB Project – a UNITAID-funded project implemented in partnership with the Global Laboratory Initiative (GLI) and the Foundation for Innovative New Diagnostics for the procurement, distribution and use of new TB diagnostic tools. GDF obtained WHO approval for the procurement of Gene Xpert machines with a value of up to 40 million, allowing GDF to make agreements to supply the machines to Uganda and Rwanda with World Bank funding. Together with experts from the GLI, GDF developed new LED Microscopy Kits for supply in early 2012. • A record number of anti-TB medicines received WHO prequalification in 2012: • 10 FLD Products from four manufacturers from India • 9 SLD products from four manufacturers from India and the Republic of Korea.
2013	• GDF has continued to provide assistance in preventing and managing stock-outs in countries through various mechanisms and tools. To prevent stock-outs and minimize the risk of transition from grants to direct procurement, GDF has been collaborating with its partners to develop and implement key mechanisms including: • Early Warning System (EWS). GDF developed EWS to collect and analyse stock levels in countries to proactively identify the risk of stock out and collectively act on with partners. EWS collates information from existing data collection systems or quantification tools used in countries such as QuanTB, eTB manager and others that have a built-in data dictionary. EWS has been piloted in several African and Asian countries and will be scaled-up in 2014 onwards. • Rapid Supply Mechanism (RSM). Based on an independent survey on root causes analysis of stock-outs in countries, GDF contributed to developing the new concept of RSM with the Global Fund which will give the Global Fund-supported countries access to GDF expanded stockpile of SLD and FLD through a fast mechanism in emergency since 2013. • MDR-TB Strategic Rotating Stockpile (SRS). In 2013, UNITAID committed US $14.9 million to GDF to double its current stockpile for MDR-TB. The SRS helps to reduce the risk of stock-outs of MDR-TB drug by guaranteeing supply and improving delivery times of SLDs. • USAID Flexible Procurement Fund. This mechanism enhances financial flexibilities by allowing countries or GDF clients to use the fund as a guarantee for all direct procurement. Through this life-saving mechanism, countries can place orders on time without having to issue an upfront payment and avoid treatment interruption. In 2013, Kenya and Pakistan placed an order through this mechanism.	• In 2013, GDF reduced the price of several key SLDs it supplies for the treatment of multidrug resistant TB (MDR-TB) by up to 27% compared to 2011 prices, resulting in a substantial decrease in the overall cost of treatment • To address the limited number of quality-assured TB products in past years, GDF has made significant progress to increase the pool of eligible suppliers. By the end of 2013, the total number of eligible suppliers increased to 29 from 12 in 2011. • In 2013, new diagnostic kits have been made available for light emitting diode (LED) microscopy, in collaboration with the Global Laboratory Initiative (GLI).

Area of focus	Activity	Results
	• Improved forecasting. In addition to monitoring missions, GDF has supported the roll-out of new monitoring tools for regular planning and enhanced programming such as QuanTB, in close collaboration with MSH. The data from such monitoring tools will be linked to EWS • GDF provides expert technical assistance to countries with a holistic approach to address immediate gaps in drug supply and establish long-term drug management capacity and overcome systematic problems. Grants provided to countries in 2013 accounts for a total of nearly USD 10 million.	

Source: CEPA analysis of Partnership annual reports, 2007-13

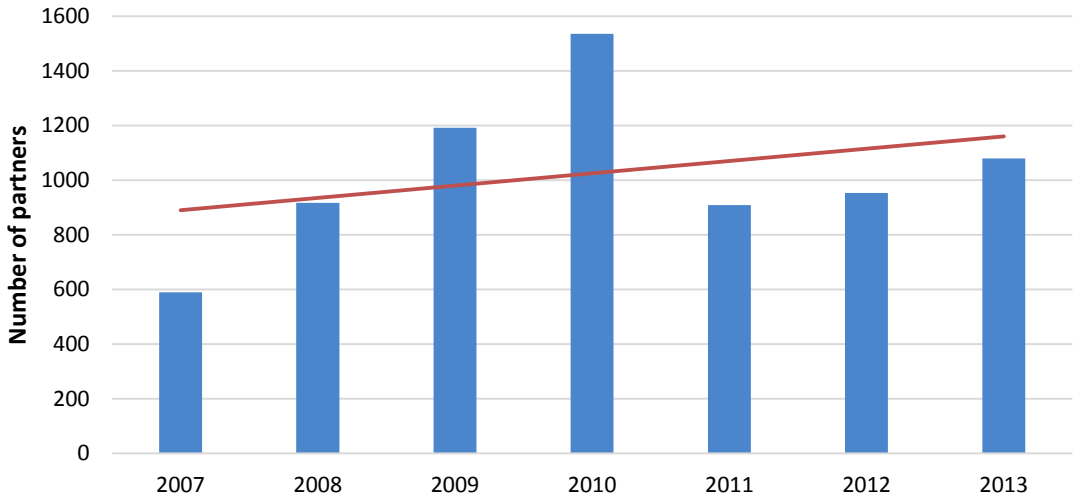
ANNEX 6 REVIEW OF PARTNER BASE

This annex presents a review of the Partnership's partner base.

Stop TB Partners

Partnership building has been a key activity of the Partnership since its inception and over the period 2007-13 the Partnership has largely been successful in building an extensive partner base. As illustrated in Figure A6.1, the number of partners increased over the 2007-10 period, followed by a drop in 2011 due to a consolidation of the Partner's database[29], and then a gradual but steady increase up to 2013.

Figure A6.1: Number of Stop TB partners (2007-13)



Source: Stop TB Partnership, Partners Directory (2013)

Partner segmentation study

A segmentation study was undertaken in 2013 to better understand the composition of the partner base and enable the Partnership to tailor its efforts to attract more partners from under-represented constituencies, geographies and specialisations. The study included 1,079 organisations registered in the Partner's Directory up to September 2013 and provides helpful insight regarding the composition of the partners base:

- *Constituency*: 75.5% of all partners are from the NGO constituency (NGOs in developing countries accounting for 65.5% of partners and in developed countries for 10%); the private sector is the second largest group and accounts for 7.4% of partners, followed by technical agencies (6.7%), and country governments (4.4%); foundations account for 2.6%, TB communities for 2.1%, multilaterals for 1.2% and donors for 0.2% of all partners.

[29] This has been explained as the result of a major "clean up exercise" of the Partner Directory, which highlighted a number of duplications/ incomplete profiles that had to be removed.

- *Geography*: The majority of partners are in the AFRO (37%) and SEARO (24%) regions, followed by AMRO (12.6%), EURO (11.8%) and EMRO (10.5%). Only 3.2% are from the WPRO region.
- *Specialisation:* 29.9% of partners are involved in advocacy, communication, social mobilisation and community engagement; 21% are involved in the delivery of health services and care; 17% provide technical assistance; 16.1% are involved in R&D; 9.2% provide funding and 6.4% are involved in the provision of drugs, diagnostics and commodities.

The shares of different constituencies, geographies and specialisations is not surprising given the relative size of each of the groups, however it is noted that the Partnership has done well in attracting non-state actors and a number of country-based organisations. That said, it has also been commented that the Partnership could do more to increase representation from certain geographies (e.g. Latin America, Russia) and certain constituencies (e.g. TB affected communities).

Partner's survey

In 2013, the Partnership also launched its first partners survey,[30] which sought to evaluate the level of satisfaction of the Secretariat's work amongst partners: overall, 73% of respondents said that they were either "completely satisfied" or "satisfied" with the Secretariat's work.[31] The survey also highlighted that:

- 70% of partners were either "completely satisfied" or "satisfied" with the Secretariat's work in facilitating communication and collaboration among partners.[32]
- 57% of partners were either "completely satisfied" or "satisfied" with the Secretariat's work in facilitating, supporting and aligning partners around key advocacy messages and resource mobilisation opportunities for the global fight against TB.[33]

As such, while these responses suggest positive performance, they also suggest some room for improvement. We understand that in the face of limited resources, the Partnership has been engaging with its partner base through information sharing/ newsletters and putting relevant partners in touch with each other. However, as discussed in the main report our review suggests that there is a need to better define the partnership-building activities of the Partnership, and in particular, targeting the limited resources towards clear objectives and intended results.

[30] The Operational Strategy mandates the Secretariat to conduct an annual partner survey to evaluate the level of satisfaction with the services and support provided by the Secretariat.
[31] Stop TB Partnership (2013) Survey to Stop TB Partners 2013, Final Report, p.12.
[32] Ibid, p.8
[33] Ibid, p.10

ANNEX 7 REVIEW OF THE CHALLENGE FACILITY FOR CIVIL SOCIETY

This annex provides a summary of the Challenge Facility for Civil Society (CFCS), its operations and evolution over the evaluation period.

Background

Launched as a pilot program in 2007, and formalised in 2008, the CFCS is "an instrument to promote the role of communities in National TB Programmes and on other high-level platforms, especially in countries supported by the Global Fund"[34] and is a key mechanism to support the Partnership's community engagement work.

Although initially designed with the objective of leading to high-level change at the country level, the purpose and objectives of the facility were subsequently revised to focus on community empowerment through awareness, case detection and social mobilisation in line with the needs and outcomes of the first two rounds of grants (as reviewed in an evaluation undertaken in 2009).[35] Moreover, the purpose of CFCS grants under Round 6 (awarded in 2014) was further re-focused to support work related to the Global Fund and roll-out of the New Funding Model (NFM).

Operational model

The CFCS provides small grants in the range of US$5,000-US$20,000 to civil society organisations. Grant duration varies between 6 and 12 months. Five rounds have been awarded between 2007-13 for a total 99 grants in 37 countries and US$1.8m in funding. Table A7.1 summarises the number of grants and amounts in each Round.

Table A7.1: Number of CFSC grants and funding amount by Round

Item	Round 1	Round 2	Round 3	Round 4	Round 5	Total
Number of grants	22	23	22	21	11	99
Funding committed (US$)	384,037	483,083	382,618	382,688	212,592	1,845,018

Source: CFCS Admin and Monitoring Sheets.

Progress on the recommendations of the 2009 evaluation

The 2009 evaluation made a series of recommendations to strengthen the processes and outcome of the facility. These are reviewed in the table below with details on progress made

[34] http://www.stoptb.org/global/awards/cfcs/
[35] Stop TB Partnership (2009) Challenge Facility for Civil Society: Preliminary Internal Review Report.

to date. In general, the majority of the recommendations appear to have been adopted and relevant reforms introduced.

Table A7.2: Progress against recommendations made in the 2009 evaluation of the CFCS

Recommendations	Progress
Revise purpose and objectives of the CFCS to make it more specific in order to attain the ultimate goal of leveraging additional funds and empowering communities	As noted above, the focus of the CFCS was revised to better aligned with the needs and work of communities (support for awareness, case detection and social mobilisation), and there has been a further re-focusing in Round 6 to support work related to the Global Fund.
Revise the CFCS application form in order to facilitate pre-screening and an efficient scoring process	The CFCS application form was changed after Round 2, requiring more detail to aid the pre-screening process. We understand that a detailed scoring sheet has also been developed for the reviewer of the proposals.
Develop an application guideline to ensure proposals received are suitable for achieving CFCS objectives	A detailed application guideline has been developed and can be accessed on the CFCS website in multiple languages. The application system has also been streamlined through an online application platform.
Develop a report form with guidance on criteria used to evaluate results and improve the monitoring and evaluation process by requesting a mid-term report and detailed financial spreadsheet	Mid-term and completion reports have been introduced since Round 3, with specific programmatic and financial indicators to be reported on.
Continue monitoring CFCS performance through review mission and documentation of good practices	CFCS commissioned another evaluation in 2013[36] and has produced good practice documents for Round 3 and Round 4[37], as well as success stories from high-performing grants.

Results

Although CFCS grantees undertake a range of activities, they focus on community empowerment through awareness, case detection and social mobilisation. Table A7.3 summarises some of the key achievements of CFCS grants in Rounds 3, 4 and 5.

[36] We understand that this document is not yet publicly available.
[37] http://www.stoptb.org/global/awards/cfcs/bp.asp

Table A7.3: Summary of indicators for Rounds 3, 4 and 5

Indicator	Round 3	Round 4	Round 5	Total
Number of beneficiaries reached	53,834	82,126	1,034,966	1,170,926
Number of trainings/ sensitisation meetings organised	4	88	34	126
Number of community volunteers trained	459	1,042	221,431	222,932
Number of people referred for testing	2,086	18,190	8,278	28,554
Number of people reached through social media	948,670	665,000	21,270,000	22,883,670

Source: CFCS Administration and Monitoring sheet Round 3 & CFCS Best Practices Rounds 4&5

ANNEX 8 PROGRESS ON RECOMMENDATIONS OF THE TB REACH MID-TERM REVIEW

This annex presents the progress on the recommendations made in the mid-term evaluation of the TB REACH initiative.

Table A8.1 provides a summary of the recommendations and reports on the progress made to date. The extent to which the recommendations have been implemented has been depicted using a "traffic light" approach: green for recommendations which have been implemented; orange for recommendations that have been partially addressed; and red for recommendations which have not yet been adopted and for which work in ongoing.

Table A8.1: Progress on TB REACH mid-term review recommendations

Key issue	*Description of recommendation*		*Progress to date*
Design of proposal process	Given the large number of proposals received, the evaluation highlighted the need to institute a two-stage application process comprising of an "intent" stage followed by a full application for the short-listed proponents (in order to improve efficiency of the application and review processes).		We understand that TB REACH has implemented this recommendation and that the application process now consists of a letter of interest followed by a detailed proposal for those shortlisted. However, despite this change the demand for support continues to be high (in Wave 4, TB REACH received over 500 letters of interest).
Sustainability and scalability of grants/ approaches	One of the key issues identified by the evaluation was the need to emphasise the sustainability and scalability of high-performing grants.		We understand this has been a core focus of TB REACH since the evaluation, which is being pursued through: • Greater collaboration with the GF to support the inclusion of successful TB REACH approaches into country concept notes under the NFM – under the Technical Assistance agreement TB REACH will share "*experiences and know-how of increased case detection and care delivery*" to countries eligible under the NFM to help them develop National Strategic Plans and Concept Notes which include successful approaches tried under TB REACH;[38] and • Increased focus on TB REACH publications to share best practices and lessons learnt, including a number of peer-reviewed publications and presentations at the annual Union Conferences. However, ensuring the sustainability and scalability of grants/ approaches however remains an ongoing challenge for TB REACH.

[38] The Global Fund and World Health Organization (2014) Provision of Technical Assistance to the Global Fund Applicants under the New Funding Model, Appendix A – Project Framework context and table, p.5.

Key issue	*Description of recommendation*		*Progress to date*
Strategic approach to second year of funding	The evaluation recommended adopting a more strategic approach to the second year of funding given lack of clarity on the objectives and selection approach/ criteria for this. The evaluation noted that second year funding for high-performing grants should be designed with the objective of promoting the sustainability and scalability of proven approaches.		Operationally, TB REACH has accepted this recommendation and clarity has been provided on the process for second-year funding, although some gaps still remain in terms of what should be presented on the application for this additional funding given the short time-lag between year 1 and year 2.
Funding for local organisations	Given the need for increased case detection at the grassroots level, the evaluation recommended the institutionalisation of measures that facilitate local organisations to access TB REACH funding.		In response to this recommendation, TB REACH has designed a separate "small-track" for local NGOs (in addition to the general track which accepts proposals up to US$1m). This enables local organisations to apply for grants with a budget up to US$200,000 to support grassroots organisations working on or wishing to improve TB case detection.
Development of a results framework	Despite the effective functioning of the independent M&E agency, the evaluation highlighted the need for TB REACH to establish a robust and detailed results framework to better track outputs, outcomes and impact.		We understand that as part of the ongoing discussions for future funding, TB REACH is developing a logic framework for new proposals that will be linked to long-term funding.
Overall financial sustainability of the initiative	The evaluation noted that given the "*unique and arguably unmet need for improved/ early case detection…the initiative should aim to diversify its resource base and continue to support and scale-up innovative approaches*".		We understand that TB REACH has now allocated all funding available under the original CIDA grant agreement and that discussion are ongoing with the Canadian Department of Foreign Affairs, Trade and Development (DFATD) for continued funding. In Wave 3 TB REACH was also able to leverage funding from UNITAID TBXpert grant to the Partnership, which allowed it to provide grants to countries for the purchase of GeneXpert machines and cartridges. Although securing long-term funding remains a challenge, TB REACH has also been in discussions with other potential donors.

Key issue	*Description of recommendation*		*Progress to date*
Governance roles	The evaluation noted that there is a need for greater strategic direction for the initiative, especially as TB REACH seeks to expand its donor base and activities.		We understand that the Programme Steering Group (PSG), which provides general oversight and guidance to the TB REACH Secretariat, will be reconstituted following the move to UNOPS and will seek to play a more strategic role going forward.

ANNEX 9 MEASURES OF TB REACH AND GDF SECRETARIAT EFFICIENCY

This annex presents the ratio of TB REACH and GDF staff to operational costs over the evaluation period, as a measure of their efficiency.

TB REACH Secretariat efficiency

Since its establishment in 2009, TB REACH has launched four funding waves, with total grant funding commitments of US$91.4m across 169 projects in 46 different countries. This process has been managed by a small staff, which grew to five members by 2012-13.

From its establishment until the end of 2013, TB REACH's staff costs totalled US$3.4m. This represents 4.4% of the funds committed during over Waves 1 to 3.[39] It should also be noted that TB REACH has also been engaged in activities other than grant commitments, including providing support to the Partnership's advocacy activities and technical assistance to successful grantees with Global Fund concept notes proposals for scale-up funding.

Feedback from consultations also indicates that TB REACH's efficiency is viewed as largely positive with stakeholders being "*surprised by what TB REACH are able to achieve with the staff they have*".

GDF Secretariat efficiency

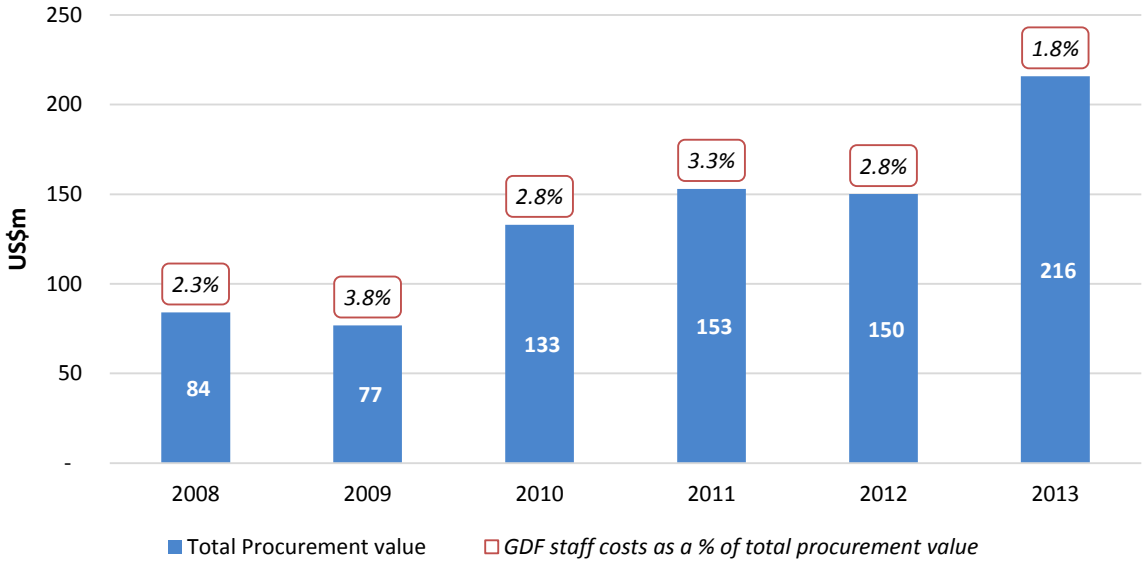
During the evaluation period, GDF procured commodities for a total value of US$855m (US$813m, excluding 2007 for which no HR data is available). Averaging over 2008-13, the ratio of staff to operational costs represented 2.7% of the total value of procurement.

However, as shown in Figure A9.2, this ratio has varied over time. It peaked at 3.8% in 2009 when staff costs were rising but procurement value was still low, and rose again to 3.3% in 2011 when staff costs surged following an increase in technical staff. Some of this variability over time is also reflective of the leadership and staffing issues that GDF faced over this time.

In 2013, declining staff costs and increases in GDF's yearly procurement value resulted in a ratio of staff to operational cost of just 1.8% of total procurement value, suggesting increasing efficiency in GDF's operations. Consultation feedback also suggests improvements in GDF's efficiency, especially following the managerial transitions.

[39] Although the Wave 4 call for proposals was launched in September 2013, Grant Agreement Letters and activities did not start until mid-to-late 2014 and hence has been excluded from our analysis.

Figure A9.2: Total value of GDF procurement, US$m, and GDF staff costs as a proportion of total procurement value (%)



Source: CEPA analysis of GDF financial reports and Partnership human resources data

ANNEX 10 RESOURCE FLOWS TO TB

This annex provides additional information on the TB funding landscape as follows:

- Funding gap in relation to the funding needs of the Global Plan to Stop TB 2006-15;
- Domestic and external funding for TB; and
- Global Fund's contribution to TB control.

Funding gap in relation to the funding needs of the Global Plan to Stop TB 2006-15

The Global Plan to Stop TB 2006-15 called for funding of US$56.1b for its ten-year period. The Plan also estimated that, unless TB funding was stepped-up, this target would be missed, leaving a funding gap of US$30.8b over the duration of the Plan (Table A10.1).

Table A10.1: Summary costs and funding gaps for the 2006-11 Global Plan to Stop TB

Area of Global Plan	Funding requirements (US$b)	Estimated funding available (US$b)	Estimated funding gap (US$b)
Implementation	47.2	22.5	24.7
New tools	8.9	2.8	6.1
Total	**56.1**	**25.3**	**30.8**
Of which 2006-10	*24.9*		
Of which 2011-15	*31.2*		

Source: Global Plans 2006-15 & 2011-15

For the first five years of the Plan, US$18b was spent globally on the fight against TB,[40] leaving an actual funding gap of US$6.9b.

The Global Plan was updated in 2011 for the second five-year period. The updated Plan revised the funding requirements upwards to US$46.7b for 2011-15 (Table A10.2).[41]

Table A10.2: Summary costs and funding gaps for the 2006-11 Global Plan to Stop TB

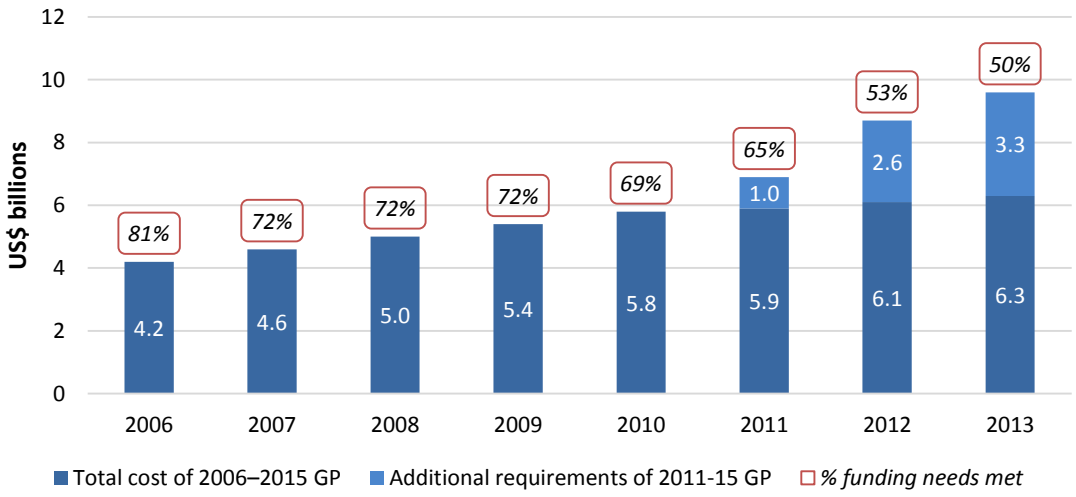
Area of Global Plan	Funding requirements (US$b)	Estimated funding available (US$b)	Estimated funding gap (US$b)
Implementation	36.9	25.9	11
Research and Development	9.8	3.8	6
Total	**46.7**	**29.7**	**17**

Source: 2006-11 Global Plan to Stop TB

[40] Global Tuberculosis Report 2012, p.53
[41] Global Plan to Stop TB 2011-2015, p.14

Part of the cost-increase was attributed to a more ambitious scale-up of treatment for MDR-TB and increased investments in R&D. Increased funding demands were also attributed to the need to address the shortfall from the preceding five years. However, as shown in Figure A10.3, both Global Plans have been significantly under-funded and the resource gap for TB has been widening over the years.[42]

Figure A10.3: Funding requirements for the Global Plans and estimated global funding for TB care and control, US$ billions



Sources: Global Plan to Stop TB 2006-15, p.63; Global Plan to Stop TB 2011-15, p.15; Global Tuberculosis Report 2012, p.53.

As Figure A10.3 illustrates, although funding for TB care and control has been rising over time, it has not been keeping up with the requirements set out in the Global Plans. Whereas 81% of funding needs were being met in 2006, only half were met in 2013.

Domestic and external funding for TB

Funding for tuberculosis control has increased substantially over the last decade. Using data from governments and international donors to assess global TB financing, in 2013 it was estimated that total funding for TB care and control (both domestic and external) grew from US$1.7 billion in 2002 to US$4.4 billion in 2011.[43] Our review of the TB funding landscape highlights the following:

- *Domestic funding for TB*: The volume of TB funding from domestic sources has been rising over the last decade; it has been estimated that domestic funding rose from US$1.5b to US$3.9b per year over the 2002-2011 period.[44] However, the increase in domestic funding for TB mostly related to increases in domestic funding in Brazil,

[42] E.g. R&D has decreased

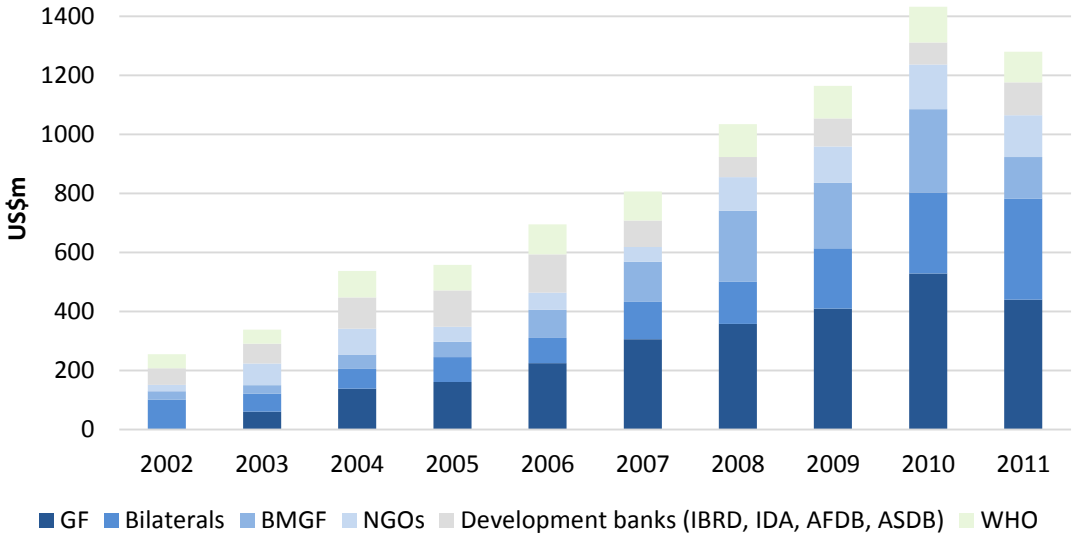
[43] Floyd, K., Fitzpatrick, C., Pantoja, A., and Raviglione, M. (2013), "Domestic and donor financing for tuberculosis care and control in low-income and middle-income countries: an analysis of trends, 2002–11, and requirements to meet 2015 targets", The Lancet Global Health, 1:e105-15.

[44] Ibid.

Russia, India, China, and South Africa (BRICS). Indeed, it has been estimated that BRICS and other upper-middle income economies could mobilise almost all of their funding needs to 2015 from domestic sources.[45] However, international donor funding remains crucial for many low and lower-middle income countries.

- *External funding for TB*: Development assistance for health for TB grew from US$0.26b in 2002 to US$1.3b in 2011, as illustrated in Figure A10.4.[46] The Global Fund has been the largest single source of development assistance for TB since shortly after its establishment in 2002: in 2011, as per IHME data, it provided over a third of all TB development assistance disbursements (34%). USAID and the Bill and Melinda Gates Foundation are the second and third largest donors respectively, as measured by development assistance disbursements. Both donors accounted for 11% of total TB disbursements in 2011.

Figure A10.4: TB development assistance disbursements 2002-2011, by assistance channel, US$m



2

Source: CEPA analysis of the IHME DAH database 2013

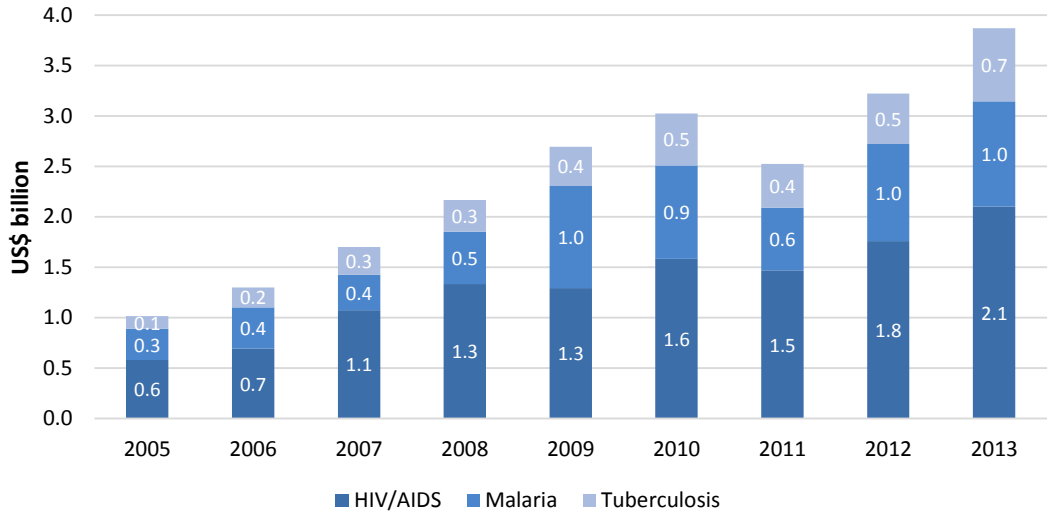
In 2013, the Global Fund provided almost 80% of external funding for TB globally.[47] Under the NFM, the Global Fund has made the decision allocate its resources for HIV, malaria and TB in the ratio of 50:32:18 for the 2014-16 allocation period.[48] From the total US$14.82b raised for

[45] Ibid.
[46] Institute for Health Metrics and Evaluation (IHME) DAH database (2013). Please note that development assistance disbursements for TB are calculated by the IHME in a different manner from the estimates of external TB funding made by Floyd et al. (2013) which were referenced above.
[47] http://www.stoptb.org/global/fund/
[48] Global Fund (March 2014), *"Overview of the Allocation Methodology (2014-2016)"*

HIV, TB and malaria for the three years of the Global Fund's NFM, an 18% share translates into US$0.9b allocation to TB per year.[49]

Figure A10.5 shows Global Fund disbursements to countries over the period 2005-13. As can be seen from the figure, the funding has been rising over time (with some declines during the Global Fund crisis period), with disbursements for TB totalling US$726m in 2013 - the highest ever in the history of the Global Fund.[50]

Figure A10.5: Global Fund disbursements by disease area, US$ billion



Source: CEPA analysis of data from the Global Fund website.[51] Note – These figures do not include disbursements for general health systems strengthening or TB/HIV.

[49] http://www.tbonline.info/posts/2014/10/31/tb-activists-call-bigger-piece-pie-global-fund/
[50] http://who.int/tb/tbteam/TBTEAMinfoupdate_March2014.pdf
[51] http://portfolio.theglobalfund.org/en/Home/Index

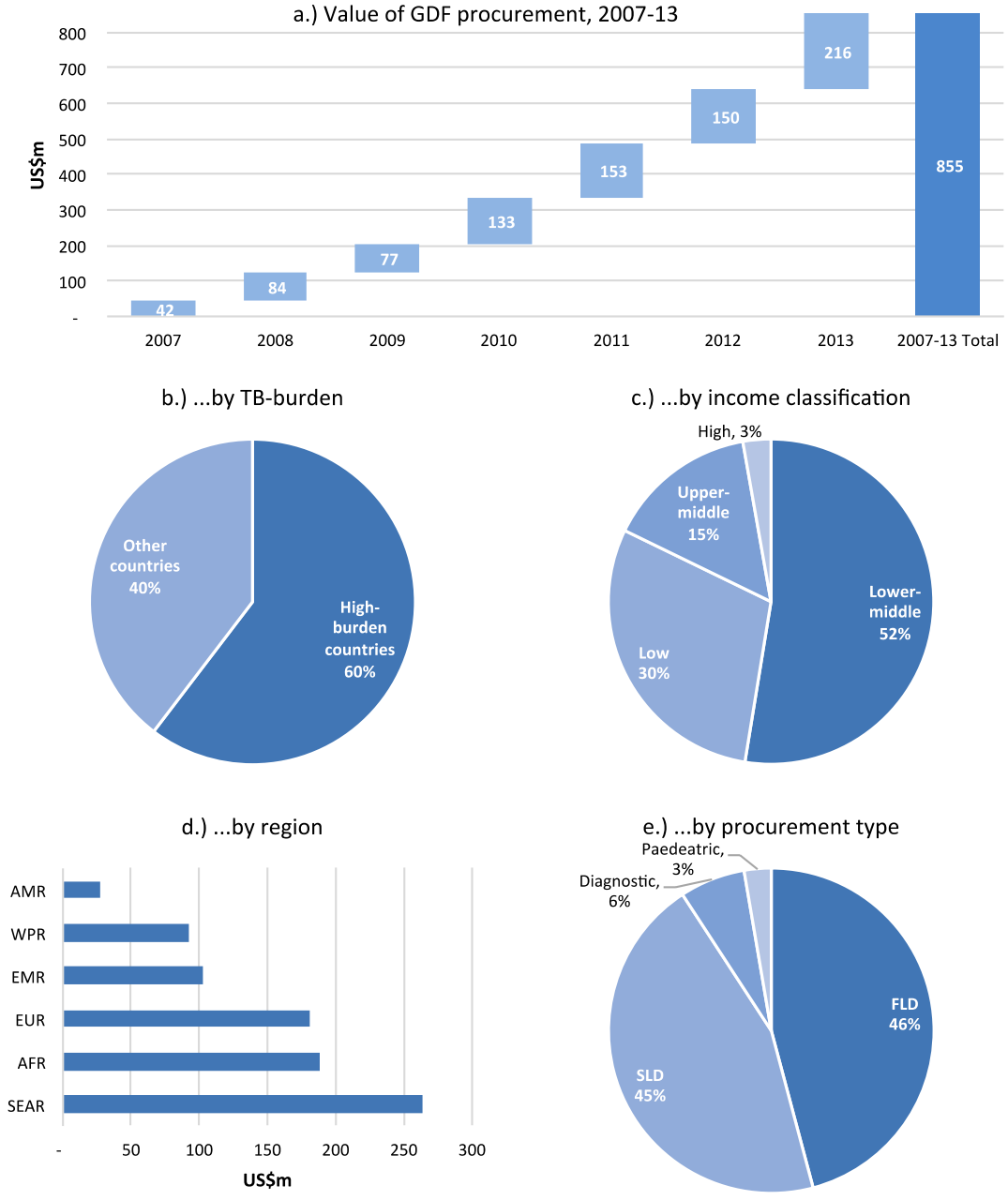
ANNEX 11 SUMMARY PORTFOLIO ANALYSIS – GDF, TB REACH AND CFCS

This annex provides a summary portfolio analysis of the Partnership's three grant-facilities: (i) GDF; (ii) TB REACH; and (iii) the CFCS.

GDF

Figure A11.1 summarises the value of procurement undertaken by the GDF and its distribution over the evaluation period. From 2007-13, the GDF delivered TB drugs and diagnostic equipment worth a total of US$855m.

Figure A11.1: GDF procurement (2007-13) summary statistics



Source: CEPA analysis of GDF data (2007-2013)

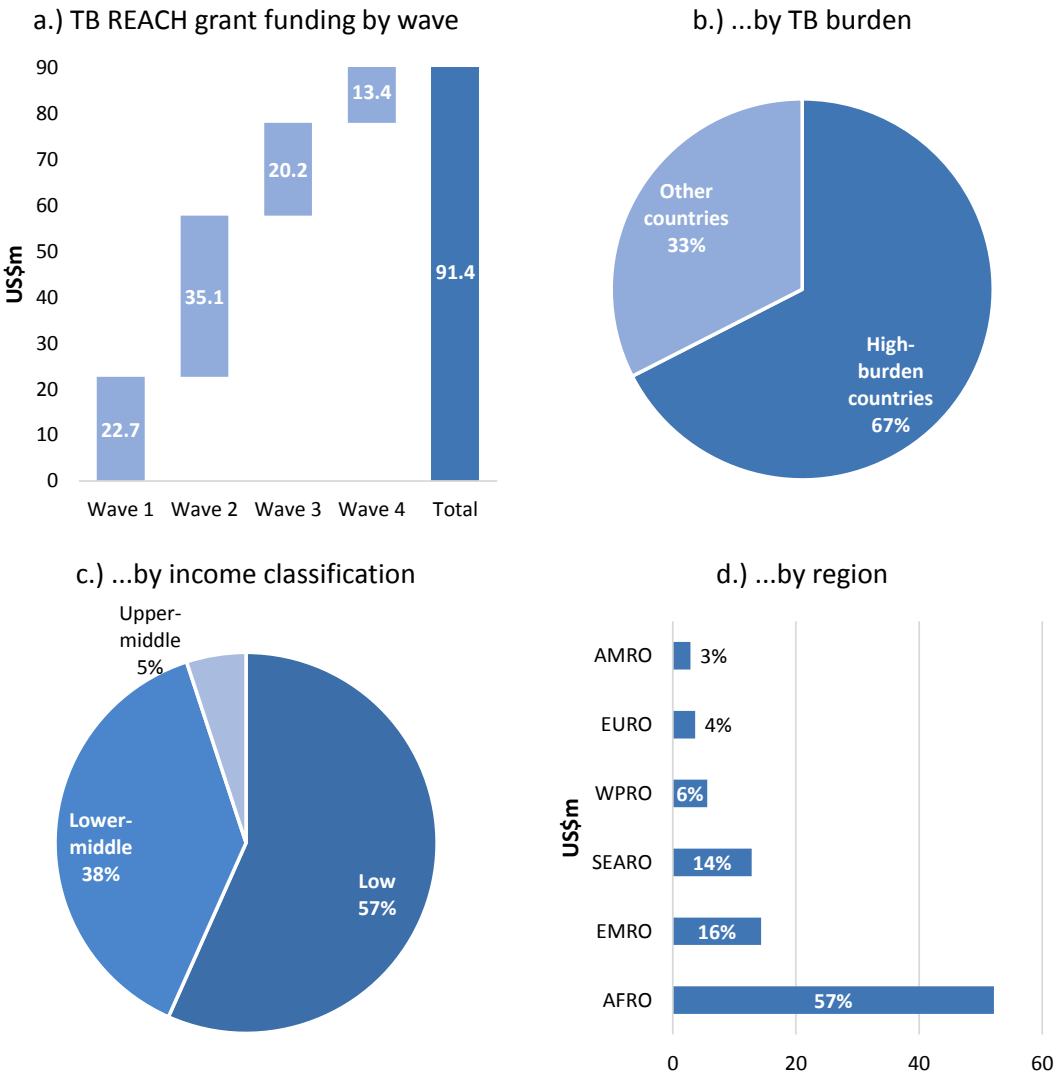
Key aspects to note are as follows:

- 60% of GDF's procurement spend had been channelled to HBCs; and lower-middle income countries accounted for more than half of GDF's procurement over 2007-13 (52%) followed by low-income countries (30%). This suggests a focus on countries that have the highest burden of TB. Region-wise the focus has been on SEARO, AFRO and EURO which have relatively higher TB burdens.
- An almost equal amount of GDF's procurement spend has been used to purchase FLDs and SLDs, with lesser focus on TB diagnostic and TB paediatric drugs to date.

TB REACH

Figure A11.2 shows the value of grants committed by TB REACH over the four funding waves and the distribution of funding by TB burden, income classification and by region. Overall, US$91.4m has been committed across the four funding waves.

Figure A11.2: TB REACH waves 1-4 grant summary statistics



Source: CEPA analysis of TB REACH portfolio

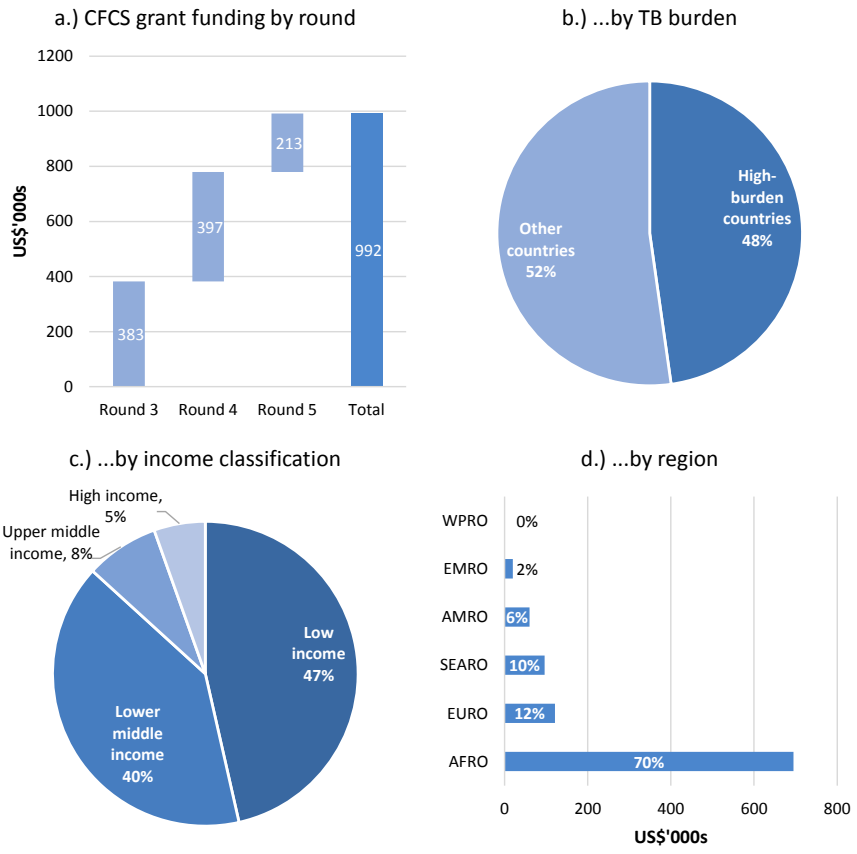
The distribution of TB REACH's grant funding in Figure A11.2 suggests that project selection is appropriately focused on the areas of greatest need:

- Two-thirds of funding has been channelled towards projects in high TB-burden countries.
- The great majority of TB REACH funding has been received by projects in low or lower-middle income countries. Funding to upper-middle income countries is accounted for by grants to Brazil, South Africa and Thailand.
- Over half of funding has been directed towards projects in the AFRO region (which has the highest number of eligible countries under TB REACH eligibility criteria), although projects have been funded in a broad range of countries in every region.

Challenge Facility for Civil Society

Figure A11.4 shows the value of grants committed by the CFCS during funding Rounds 3-5, and the distribution of funding by TB burden, income classification and by region. A total of US$992,000 was disbursed over the three rounds.

Figure A11.4: CFCS Rounds 3-5 grant summary statistics[52]



Source: CEPA analysis of CFCS portfolio (rounds 3, 4 and 5)

[52] Income-classification of recipient countries is according to July 2014 World Bank classifications

The distribution of grant-funding in Figure A11.4 shows that the CFCS has reached a broad range of recipients:

- Just under half of CFCS funding was committed to HBCs.
- The majority of funding was committed to low and lower-middle income countries. The 5% of funds received in high-income countries represent grants disbursed to organisations operating in Russia.
- The great majority of funding was directed towards recipients based in the AFRO region.

ANNEX 12 BENCHMARKING OF THE PARTNERSHIP WITH SIMILAR ORGANISATIONS

This annex provides details of the benchmarking exercise of the Stop TB Partnership with PMNCH and RBM.

Approach to the benchmarking

We selected PMNCH and RBM as comparator organisations as they present the following characteristics:

- are both WHO hosted partnerships with some similar governance and management structures (e.g. Board, Executive Committee, Secretariat);
- work in similar areas of advocacy and partner coordination (although we do recognize that they also have key differences in that the Stop TB Partnership includes operational initiatives that fund country-level programmes/ projects, which the other two organisations do not have).

Our approach to the benchmarking is based on: (i) the review of a limited number of documents from the two organisations, including their most recent external evaluations, their annual and financial reports, and selected strategy documents; (ii) focused consultations with a member of the RBM Secretariat; and (iii) our knowledge of PMNCH. We have also reviewed findings from other global benchmarking exercises, specifically the World Bank Report on Global and Regional Partnership Programmes (2011) and the Multilateral Aid Review by DFID (2012).

An important caveat to note is that it is very challenging to compare like-with-like, not only because of the different overall structure and objectives of any comparator organisations, but also because of their different approaches is measuring costs. Thus the analysis has only been undertaken at a high-level and mainly relying on qualitative information, with limited triangulation.

How does the Stop TB Partnership compare?

Although difficult to draw concrete comparisons, given the different structures and context in which the comparator organisations operate, the benchmarking exercise highlights the following:

- **Relevance**: All three organisations have relevant mandates, and as partner-centric organisations, play a critical role in advocacy, communications and partnership building within their respective sectors.
- **Existence of a clearly defined strategy**: Issues with the lack of a clearly articulated long-term strategy defining intended objectives, how they will achieve impact and measure results have been noted for all three Partnerships in consideration. We note that PMNCH has done well in developing successive three-year strategies and annual

workplans, which are also made publically available on its website.[53] The Stop TB Partnership has also recently developed an Operational Strategy, although as noted, it requires further streamlining and a better articulation of its intended objectives and results.

- **Levels/ success with fund raising:** While an important challenge, especially in the post financial crisis era, we understand that PMNCH has been relatively successful in raising unspecified funding and building a large donor base.
- **Efficiency of governance arrangements**: All three organisations are governed by constituency-based Boards; however, the latest evaluations of both PMNCH and RBM raised concerns about the level of representation of each constituency on the Board. The Stop TB Partnership Board appears to have become more efficient post the reforms, with a greater focus on ensuring adequate constituency representation. In terms of Board size, the Stop TB Partnership Board has been reduced and is now similar to that of the two other organisation (see Figure 4.5 in Section 4).
- **WHO PSC**: Up to 2012, the Partnership had benefitted from a reduced PSC of 7% for its Secretariat costs, lower than the 13% PSC charged by WHO to PMNCH and RBM.

We do not draw any major conclusions from this benchmarking exercise, given limited comparable information. Our main finding is only that all three partnerships have carved out a clear role for themselves in their respective sectors however some have been noted to lack a clearly defined strategy that sets out their focus activities and how they will achieve results.

[53] The external evaluation notes that the "development of a Strategic Framework for 2012-2015 was developed in a consultative manner, but as a result lacks the necessary focus and clarity to provide proper direction to its partners and the secretariat", p. 9.

Table A12.1: Benchmarking of the Partnership with other similar organisations

Information metric	PMNCH	RBM	STP
Background information			
Sector	RMNCH	Malaria	TB
Mandate	Focus on MDGs 4 and 5, with a mission to "[support] partners to align their strategic directions and catalyze collective action to achieve universal access to comprehensive, high-quality reproductive, maternal, newborn and child health care".[54]	Its mandate is "to convene, coordinate and facilitate communication with key stakeholders"[55] on the global and national response to malaria.[56]	Aims to act as a "collective force" to "reduce the toll of TB worldwide and ultimately achieve a world free of TB"[57] with a mission to: "ensure that every TB patient has access to effective diagnosis, treatment and cure; to stop transmission of TB; to reduce the inequitable social and economic toll of TB; to develop and implement new preventive, diagnostic and therapeutic tools and strategies to stop TB"[58]
Key activities	• Promotion of knowledge and innovation • Advocacy to mobilise and consolidate resources • Promotion of accountability for resources and results	• Advocacy • Resource mobilisation • Policy and regulatory • In-country planning • Financing	• Advocacy and communications • Partnership building and coordination • Universal access to medicines and diagnostics through GDF

[54] http://www.who.int/pmnch/about/en/

[55] This is the mandate cited in their 2013 external evaluation. Source: Boston University (2013) External Evaluation of the RBM Partnership 2009-13.

[56] However, as per consultation feedback, it should be noted that the RBM Partnership's mandate has been evolving over time, recognising the external environment and country needs; the original mandate was centred on the harmonisation of efforts around a global technical strategy for malaria; as the Global Fund financing was being scaled-up, the Partnership's mandate evolved to support coordinate action around resource mobilisation for countries to successfully apply for and use Global Fund funds at the country level; whilst in the last few years with the development of the new funding model and the post-MDG framework, RBM's focus has centred around multi-sectoral engagement for malaria control driven by country needs and priorities.

[57] Stop TB Partnership (2012) 2013-2015 Operational Strategy, Stop TB Partnership Secretariat, World Health Organization.

[58] Stop TB Partnership (2001) Basic Framework for the Global Partnership to Stop TB, Stop TB Partnership Secretariat, World Health Organization.

Information metric	PMNCH	RBM	STP
		• Procurement and supply chain management • Communication and behaviour change methodologies • M&E • Humanitarian crises	• TB diagnosis innovation through TB REACH
Year established	2005	1998	2001
Funding (annual US$ m)	2013 budget: $14.7m[59] 2012 budget: $14.3m	2013 revenue: $17.8m[60] 2012 revenue: $18.4m	2013 revenue: $78.6[61] 2012 revenue: $64.2
Comparison criteria			
Overall significance			
Relevance/ comparative advantage within focus sector	PMNCH's added value is defined as follows: "To be an institutional platform bringing together and enhancing the interaction of partners focused on improving the health of women and children, working across the reproductive, maternal, newborn and child health continuum of care. In essence, The Partnership enables members to share strategies, align objectives and resources, and agree on interventions to achieve more together than they would have been	As a global consensus building mechanism, the comparative advantage of the Partnership has been: (i) to ensure that countries and partners can access and use financing effectively to scale-up interventions to maximise impact; and (ii) ensure coordination of efforts to avoid duplication and fragmentation.[63]	The Operational Strategy 2013-15 describes the Partnership's comparative advantage as follows: "The Partnership Secretariat has a strong comparative advantage in global advocacy efforts as a neutral voice in TB advocacy and resource mobilization, with the ability to amplify the voices of partners. The Secretariat facilitates and links partners with common areas of interest and creates a platform to facilitate consensus and coordinate advocacy approaches. Finally, the Secretariat should continue its flagship

[59] PwC (2014) PMNCH External Evaluation, Final Report and Appendices, 25 June 2014.
[60] RBM, 2013 Annual Report
[61] Stop TB Partnership, 2013 Annual Report
[63] Consultation feedback.

Information metric	PMNCH	RBM	STP
	able to achieve individually".[62] The 2013 evaluation notes that PMNCH's strategic positioning is valid, it is unique and adds value.		initiatives, GDF and TB REACH, since it has initiated these programmes and has the comparative advantage of applying lessons learned from implementation".[64]
Efficiency and effectiveness			
Existence of a clearly defined strategy	Its 2012-15 strategic framework is seen to be too general to provide direction, with its work on accountability having less traction than that on knowledge sharing and advocacy and communication. Its approach to country engagement requires more strategic articulation.[65]	RBM does not have a specific long-term strategy[66] but its work is guided by bi-annual workplans approved by the Board based on priority functions and areas of focus. The workplans outline activities for all the mechanisms of the Partnership. This allows the Partnership to be responsive to needs and the changing environment.	The Partnership has not had a clearly defined strategy from the outset, with its work being guided by the objectives of the Global Plan to Stop TB. The development of an Operational Strategy for 2013-15 is a step in the right direction, albeit this strategy needs further development and specificity.
Performance with regards to fund raising • **Existence of a resource mobilisation strategy**	Does not have a resource mobilisation strategy, but its evaluation notes that it has been successful in increasing the level of unspecified funding "demonstrating the increased trust donors have in PMNCH".[67]	RBM does not have a resource mobilisation strategy, but it does have a Resource Mobilization Sub-Committee (RMSC) with the objective of developing a resource mobilization strategy that would include both traditional and new donors as well as innovative financing mechanisms, aimed at filling the GMAP funding gap.	With the development of the Operational Strategy more emphasis has been placed on resource mobilisation and fundraising for TB through advocacy and communications. Although significant efforts have been made in recent years, the lack of a defined resource mobilisation approach has constrained the ability of the Partnership to focus on raising resources

[62] PMNCH Brochure, 2013, available at http://www.who.int/pmnch/knowledge/publications/20130620_pmnchbrochurelowres.pdf?ua=1
[64] Stop TB Partnership (2012) Stop TB Partnership Operational Strategy 2013-15, p.3
[65] PwC (2014) PMNCH External Evaluation
[66] However, we do note that during its initial period of operation it did develop a Global Strategic Plan (2005-15).
[67] PwC (2014) PMNCH External Evaluation, p.41

Information metric	PMNCH	RBM	STP
• **Number and diversity of donors** • **Proportion of unspecified funding**	• Majority of its funding is unspecified in nature (66% in 2013) and through multi-year agreements (80% in 2013). • Number of donors in 2013: 12[68]	• Number of donors in 2013: 10[69]	for TB. More needs to be done to ensure the Partnership has a broad donor base that will ensure continuity in its funding. • Number of donors in 2013: 9[70]
Functioning of the governance arrangements	Inclusive Board, but considered too large with uneven engagement from members. Executive Committee not viewed as playing an adequate role.	General consensus that the Board has had a positive impact, although it is considered large and unwieldy. Currently the Board consists of the Chairman and Vice Chair along with 21 voting members.[71] However, the evaluation notes some challenges with regards to: the appropriate level of Board guidance and oversight of Secretariat's activities; issues of accountability surrounding the constituency structure; and the limited ability of members to 'represent' their constituencies.	The Board had faced several issues in the past with an obsolete modus operandi and lack of focus. However, recent reforms have restructured the Board (in terms of smaller constituency-based composition with clearly defined focus and procedures). Early feedback from consultations suggests that it has been strengthened and its efficiency has been improving.
Functioning of the Secretariat	Small and agile Secretariat, but supported by a large consultancy budget and limited clarity on roles/ work plans.	The evaluation notes that the Secretariat should be acknowledged as a success: knowledgeable technical staff members and a highly energised work environment. However, it also notes that operates in the	Small Secretariat, whose efficiency has been improving over the years. Recent feedback positively notes the amount of work that it has been able to achieve give its "skeleton staff".

[68] PMNCH, 2013 Financial Report, p.3
[69] In order of size: Abu Dhabi (28%), USAID (17%), Gates Core (11%), UK DFID Data Strengthening (11%), UK DFID (11%), Gates GMAP (10%), WB (6%), Islamic Development Bank (2%), Kuwait Fund (2%), GFATM Gap Analysis (2%).
[70] Stop TB Partnership, 2013 Annual Report, p.51
[71] http://www.rbm.who.int/mechanisms/partnershipboard.html

Information metric	PMNCH	RBM	STP
		context of chronic financial scarcity, a structurally difficult hosting relationship, and limited human resource flexibility.[72]	
Cost of the Secretariat	• 12 Secretariat staff • In 2013, the total secretariat staff budget amounted to US$3m.	The Secretariat is comprised of the Executive Director supported by technical and administrative staff.	• 17 Secretariat staff (excl. GDF and TBR) • In 2013, Secretariat costs (excl. GDF and TBR) amounted to US$3.5m.
Administrative costs • **Costs of administrative staff** • **WHO PSC**	• Of the total Secretariat costs, $2.25m is for technical staff and US$0.75m for administrative staff. • 2010/11 WHO PSC of $1.9m (13%)[73]	• No data on technical vs. administrative staff available. • 2010/11 WHO PSC of 3.3m (13%)[74]	• In 2013, Secretariat had 12 technical and 5 support staff (excl. GDF and TBR). • 2010/11 WHO PSC of $9.2m (7%)[75]
Results			
M&E Framework	The evaluation notes that "the PMNCH secretariat has not put a performance or monitoring & evaluation framework in place for all its activities. The secretariat has put results frameworks and log frames in place that are agreed with individual donors to monitor and report on specific grants."[76]	The evaluation notes that "monitoring and evaluation has been central to the RBM Partnership's work from the very beginning both within countries to track and guide the implementation of malaria programs and internationally to inform the global community on progress".[77] Further, we understand that RBM has a KPI framework for its Board, which is based on the bi-annual work plans.	The Stop TB Partnership does not have an overarching results framework and reporting has focussed on activity reporting rather than results.

[72] Boston University (2013) RBM External Evaluation, p 24-16
[73] WHO (2013) Administration and management cost study, p.41 available at http://apps.who.int/gb/pbac/pdf_files/Eighteenth/PBAC18_3-en.pdf
[74] Ibid, p.41
[75] Ibid, p.41
[76] PwC (2014) PMNCH External Evaluation, p.38
[77] Boston University (2013) RBM External Evaluation, p. 17.

Information metric	PMNCH	RBM	STP

Key achievements to date	The 2013 evaluation notes the following key achievements:
	• PMNCH has achieved significant visibility for the RMNCH cause.
	• PMNCH has established a clear added value in bringing all partners together around a common agenda
	• The Forum is a PMNCH flagship event where a range of high level delegates in the RMNCH space come together and draw significant value from the networking and sharing of ideas.
	• Strength and comparative advantage of PMNCH in the area of advocacy including PMNCH's key role in the development of the Global Strategy for Women and Children; PMNCH's advocacy efforts since 2008 to elevate MNCH issues at the G8 summits among decision-makers, which resulted in the launch of the Muskoka Initiative in January 2010; PMNCH led the efforts at the World Prematurity day, November 2012 which gained a lot of media coverage; PMNCH played a coordination and advocacy role in the launch and development of the ENAP and its adoption as a resolution at the WHA in May 2014.
		The 2013 Annual Report notes that through dedicated advocacy and lobbying, the RBM Partnership has given impetus to key global developments, which transformed the malaria landscape. Key developments in malaria control since the year 2008:
		• Malaria is maintained as a priority on the UN agenda: In 2008, recalling the Abuja pledges of 2000, the UN Secretary General called for achieving universal coverage by 2010.
		• A unified action plan is collaboratively developed: In 2008 RBM's Global Malaria Action Plan (GMAP) was adopted by the malaria community as a roadmap for malaria control and elimination over the next decades
		• Resources for the malaria fight increase dramatically: international disbursements to malaria-endemic countries increased from less than US$ 100 million in 2000 to US$ 1.60 billion in 2011; they were estimated to be US$ 1.94 billion in 2012 and US$ 1.97 billion in 2013.
			Key achievements over 2007-13 are:
			• Strengthened engagement with the GF resulting in increased allocation of resources for TB, higher TB grant disbursement, and support for engagement of TB communities;
			• Increasing resource TB flows through targeted high-impact activities such as the BRCIS initiative and TB and Mining;
			• Fostering innovation in TB case detection through TB REACH grants;
			• Contributing to progress in achieving the Global Plan objectives through GDF's role in:
			  ○ increasing supply of TB drugs and diagnostics; and
			  ○ reducing cost of TB treatment, especially for SLDs.