



Trends in International Funding for TB Control

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Prepared for the Resource Mobilization Task Force
of the Stop TB Partnership

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The opinions expressed in this survey do not imply the expression on part of the WHO Secretariat or the Stop TB Partners. The data collected from donors have been aggregated and can not be made available in any other form.
This document has not been formally edited.

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¹ Set up by the Stop TB Partnership Coordinating Board in December 2003 comprising: Francesca Boldrini, Patricia Carlevaro, Joanne Carter, Marcos Espinal, Fraser Fowler, Brad Herbert, Irene Koek (Chairperson) ; Yasuhisa Nakamura, Ernest Loevinsohn, Mario Raviglione, Nina Schwalbe (now at the Global TB Drug Alliance), Billy Stewart, Joelle Tanguy, J. Tracey, Anant Vijay (Secretary)

List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
CDC	Centers for Disease Control and Prevention
DAC	Development Co-operation Directorate (of the OECD)
DFID	Department for International Development (UK)
ECHO	Humanitarian Aid Office of the European Union
GAVI	Global Alliance for Vaccines and Immunization
GDF	Global TB Drug Facility
GFATM	Global Fund to Fight Aids, TB and Malaria
GHP	Global Health Partnership
HBC	High Burden Countries
HIV	Human Immunodeficiency Virus
HLF	High Level Forum on the Health Millennium Development Goals
IDRC	International Development and Research Centre (Canada)
IUATLD	International Union Against Tuberculosis and Lung Disease
JICA	Japan International Co-operation Agency
KNCV	Royal Netherlands Tuberculosis Association
MAP	Multi-sectoral AIDS Program (World Bank)
MDGs	Millennium Development Goals
OECD	Organization for Economic Co-operation and Development
OSI	Open Society Institute
PEPFAR	(US) President's Emergency Plan for HIV/AIDS Relief
PRSP	Poverty Reduction Strategy Paper
R&D	Research and Development
STB	Stop TB
SWAp	Sector Wide Approach
TB	Tuberculosis
TDR	Special Programme on Research and Training in Tropical Diseases (WHO)
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

Rationale

The Global Partnership to Stop TB, a coalition of some 400 partners, is concerned about the level of resources available to support TB control. The Partnership's Resource Mobilization Task Force commissioned this study to review external resource flows earmarked for TB and the attitudes of key development agencies for financing TB control. This work is intended to feed into efforts to mobilize resources by the Stop TB Partnership and its collaborators.

Study Methods

The study solicited data from bilateral and multilateral agencies through a questionnaire and follow-up communications. Of the 30 agencies surveyed, 16 responded with varying degrees of completed information, while 8 said the questions were not applicable because they provided no funding specifically earmarked for TB. This gave a response rate of 24/30 (80%). Repeated efforts were made to gather data from other respondents and the period for responses was extended to achieve this rate. The respondents were asked to provide information on their commitments to TB control activities for the years 1999 to 2003, pledged commitments for 2004, as well as information on funding priorities and emerging trends. To supplement the data collected through the survey, other existing sources of information were used to compile an overview of international TB funding.

Major Findings and Conclusions

Levels and channels of funding

- Levels of funding earmarked for TB rose substantially and consistently from 1999 to 2004. The Global Fund to Fight AIDS, TB and Malaria (GFATM) mobilized additional funds for TB, although disbursements to countries and actual in-country spending lagged behind the data on GFATM's available funds used here.
- This is reflected in rising levels of funding available in the high-burden countries, identified by WHO in its annual Global TB Control reports. These suggest dramatic increases in some cases – funding available more than doubled for 8 high-burden countries between 2002 and 2005. Again this is available funding for 2005 – actual expenditure is likely to be lower in some cases. And some of these countries still face a gap in financing their plans for TB control.
- The majority of TB funding was allocated directly from development agencies to countries, with a rising share allocated through global channels (particularly GFATM).
- The Global Fund is of substantial and growing significance in TB funding. The data suggest that GFATM funding was additional to other TB funding, at least to 2003, as the amount allocated via other sources rose and then stabilized. The figure for 2004 shows an absolute decline in non-GFATM funding.
- Half the development agencies that responded to the survey identified TB as a priority. For others, the interest in TB related to its importance in poverty reduction and contribution to the achievement of the MDGs.

- Given the growing importance of GFATM, the uncertainty over its future level of funding brings considerable uncertainty to future TB funding prospects. The Stop TB Partnership needs to continue looking at this issue as the future of GFATM becomes clearer, whilst at the same time monitoring what is happening to other funding sources for TB activities (including country health budgets).
- Given that donor contributions, either directly or through the GFATM, will be maintained at the 2004 level or at best double, the HBC will need to find substantially more funds from domestic sources to meet the financing needs of TB control for the next decade. This will be very difficult for low income and poor countries.

Geographical spread

- Spending grew in all regions between 1999 and 2004, with fastest growth in Eastern Europe/Central Asia (by a considerable margin).
- Most regions saw a steady increase – in Eastern Europe/Central Asia and South Asia, however, funding was more volatile.
- There was an increase in all regions in 2004, notably Africa and South East Asia.
- The highest proportion of spending went to South Asia (which includes India). This was true overall, and for each year from 1999 to 2003. In 2004, Africa/Middle East became the largest recipient.

Integrated funding – its implications for TB

- The survey only looked at funding that agencies could identify as allocated for TB control and a share of GFATM funding. Clearly it could not identify funding that is not earmarked for TB - for example funding that is provided as budget support to the national Treasury, or funding for health sector programmes, part of which may be used for TB control services. As the use of budget support and sector funding rises, it is becoming more difficult to obtain comprehensive information on total external funding for TB activities through a survey of development agencies. Analysis at country level could look at the picture in terms of funding reaching TB-related services, possibly for a sample of tracker countries. WHO has been developing some routine country level TB funding analysis.² The Global Health Resource Tracking Working Group, convened by the Centre for Global Development is taking work forward on improved expenditure tracking, focussing on support to national governments.
- The TB community needs to understand how to work most effectively within an environment where substantial aid flows are linked to PRSPs with budget support or to broader health plans and are not earmarked for specific diseases (or even to health). The Stop TB partnership may want to explore how to promote such an understanding.

Research and development

- 3% of the funding reported was earmarked for research and development. Foundations tended to fund R&D directly and specifically, bilaterals did not. R&D funding was particularly

² WHO. The 2002-5 *Global TB Control Reports, Surveillance, Planning, Financing* includes analyses of data collected annually for selected countries.

volatile. There appears to have been a gradual decline from 2002-2004, despite a sizeable increase in the level of overall international funding for TB. This is an area where analysis of funding flows can (and should) be carried out centrally and analysed to provide a picture of funding trends.

1. Introduction

The Global Partnership to Stop TB is an international initiative involving some 400 organizations. It was set up to accelerate social and political action to stop the unnecessary spread of tuberculosis around the world. The Partnership works towards achieving the goals of the Global Plan to Stop TB,³ and to control and eventually eliminate TB as a global health threat. Twenty-two countries have been identified as having a particularly high burden of TB.

The Stop TB Partnership has been concerned about the level of funding available for tackling TB – indeed in 2004 it believed that there had been an overall decline. According to the Terms of Reference for this piece of work:

A main constraint in moving ahead is the lack of resources, partly due to relative decline in funding for TB, compared to the overall increase in funding for other diseases. The shortfall has been significant. To mobilize resources in a systematic manner the STB Partnership needs to undertake a massive effort aimed at mobilizing resources for TB, identifying levels of current resources devoted to TB and bringing in new donors. The enhanced resources are needed to increase the operations of the Global Drug Facility to provide TB drugs under grants to support implementation of the national programmes to control TB, and to support the development of new tools, drugs diagnostics and vaccines.⁴

This need for increased resources for TB is occurring at a time of dramatic change in overall development funding patterns. More multilateral and bilateral aid money is going to general budget support or to fund Sector-wide Approaches (SWAs). In these forms of financing, aid money is not specifically earmarked for a particular area such as TB. At the same time, many new global health initiatives have started – of particular relevance to TB is the Global Fund to Fight AIDS, TB and Malaria (GFATM). These global initiatives bring new opportunities and challenges, but also increased uncertainty about likely levels of funding for TB in the future.

To address the resource gap in a systematic manner, the Partnership established a Resource Mobilization Task Force, which involves a number of the Stop TB partners. The aims of this Task Force⁵ include:

- more accurately quantifying the current resource levels available to tackle TB (and using this information to mobilize more resources for TB control) and
- understanding the decision-making processes that determine what resources are actually made available by the various organizations involved.

The Stop TB Partnership aims to maintain or increase the resources being made available by existing partners and to attract new donors to TB funding.

The Task Force on Resource Mobilization commissioned a survey of existing and potential multi- and bi-lateral development agencies in April 2004. It was to obtain data on recent and projected expenditure on TB for the period 1999-2004. The survey, undertaken jointly by the Stop TB

³ WHO (2001), *Global Plan to Stop TB*. [WHO/CDS/STB/2001.16]

⁴ Stop TB Partnership (2004). *Terms of reference for the donor survey*.

⁵ This Task force was converted into an Advisory Group as a result of the Coordinating Board decision at its Beijing 2004 meeting.

Partnership Secretariat and the HLSP Institute (formerly the Institute for Health Sector Development, IHSD), aimed to:

- establish a baseline and quantify the international resources currently available for TB funding,
- present an overview of recent funding patterns and identify any trends,
- outline some of the factors that may explain these trends by reviewing how individual organizations decide on their funding for TB.

From the start it was recognized that the study would only be able to identify funding that the agencies themselves earmarked for TB activities, and that this would not capture the entire donor funding eventually used for TB activities at country level.

This report draws on the findings from the survey and gives overall estimates of international funding allocated for TB control from 1999 to 2004.

2. Methods

2.1 The questionnaire and survey

Consultants from HLSP, in liaison with the Task Force on Resource Mobilization, developed a questionnaire for development agencies. The questionnaire was sent to organizations that provided in-kind, logistical and/or financial support to TB initiatives, either directly or indirectly. Any major development agency that had funded TB activities since 1999 was included. An explanatory letter accompanied the questionnaire – it was signed by the Chairperson of the Stop TB Partnership's Resource Mobilization Task Force and by the Co-ordinator of the Global Partnerships for Communicable Diseases.

As planning for the survey progressed, it became clear that it would be efficient to conduct a similar survey of malaria funding at the same time. Questions about both diseases were included in the same questionnaire.

Thirty organizations were sent the questionnaire in July 2004. This included 17 bilateral agencies and 6 development banks. As there was a recent study of funding for TB from the major foundations,⁶ these foundations were not surveyed again for this study. The findings of the survey are summarized in Annex B.

The surveyed organizations were asked to provide detailed information on their financial contributions to TB for 1999-2003 and pledged contributions for 2004.

The questionnaire also included a series of questions about the agency's objectives in supporting TB and its priorities for funding. Further questions sought to identify factors that might motivate larger contributions for TB.

Of the 30 organizations which were sent questionnaires:

- 16 responded with varying degrees of completed information on TB,
- 8 replied that the survey was not applicable to their organization – i.e. they did not directly fund TB activities⁷,
- A number repeatedly promised to fill in the questionnaire, but no reply was received.

With the exception of the Asian Development Bank, none of the regional development banks provided any financial data for the survey – however the Stop TB Partnership is not aware of any TB-specific financing from these organisations.

The response rate was thus 80% (24/30).

The questionnaires were sent out in July 2004, and replies accepted until early November that year. There were repeated follow-up contacts to remind organizations to fill in the questionnaire. Given the support for the questionnaire from the Task Force and the seniority of the signatories of the accompanying letter – plus the work on reminding people and the policy of the project team to accept data in any format – the response rate was somewhat low.

⁶ Open Society Institute (2003). *Foundations Involved in Tuberculosis (TB) Control Activities – A Study by the Open Society Institute.*

⁷ Of these 8 agencies, 3 did fund malaria-specific activities.

As well as the response rate, the incompleteness of many responses posed a problem – many respondents were initially unable to provide financial data for the whole period requested. The Stop TB Partnership Secretariat therefore made a determined effort to get more data in the first half of 2005.

Several organizations requested that the data they provided be used in an aggregated, non-attributable format. The request for confidentiality is respected in this report.

In general, questionnaires to development agencies meet with many practical problems when asking about disease-specific funding, and this survey was not an exception.

2.2 Additional sources of data

In order to make the TB funding estimates more complete, the responses to the survey were supplemented by data from 4 other sources:

- A 2003 survey of foundations' support for TB.⁸
- A Stop TB funding survey from 2000⁹ which provided additional data for 1999 and 2000.
- Data obtained through the Stop TB Partnership on the Global TB Drug Facility.
- Published information about GFATM funds.¹⁰ This was necessary because, out of the major donors to GFATM, only Canada, UK and USA provided detailed financial information to this survey. In order to make the estimates more complete, a share of all other contributions to the Global Fund was included. The share used is 13% of GFATM contributions from other donors, reflecting the overall percentage of GFATM funding which was committed to TB. In order to analyse how funds for TB were allocated amongst regions, data was obtained on disbursements by GFATM to TB projects by country.¹¹

Two different types of figure are used about GFATM – overall funds available and actual disbursement to countries. The former figure is larger, because of delays in disbursement. Total budgets for TB programmes approved by GFATM were some US\$904 million by the end of 2004 - of this only US\$139 million had been disbursed.¹² Then there is a second delay before disbursed funds are actually spent.

Disbursement levels for TB are higher than for the Global Fund as a whole. For TB, 15% of lifetime budgets (33% of year 1 and 2 budgets) were disbursed. The comparable proportions for all GFATM programmes were 9% and 24% respectively.

It should be noted that some international funding for TB is not reflected in this report. For example, Japan contributed US\$53 million over the period 2000-3 and Italy US\$3.6 million in 2001-3. However the data provided is too incomplete to include in this analysis.

⁸ Open Society Institute, *op. cit.*

⁹ Stop TB (2000). *Survey of External Financial Commitments for TB Control Activities in Developing Countries*. The results of this survey are presented in Stop TB Partners' Forum (2001) *50/50: Towards a TB-free future*. Available data on actual contributions was included for years 1999 and 2000 for agencies which did not respond or only partially responded to the current survey.

¹⁰ Data from www.theglobalfund.org – all Global Fund data is up to December 2004.

¹¹ Data from www.theglobalfund.org

¹² This excludes programmes classified as TB/HIV, valued at US\$296 m of which US\$42 m (14%) has been disbursed to date.

3. Findings – Trends in TB funding

3.1 Overall Financial Contributions to TB control activities

Table 1 and Figure 1 show estimated total financial contributions to TB by the development agencies identified through the various sources of information. The sources are:

- the 2000 and 2004 surveys initiated by the Stop TB Partnership,
- the 2003 survey of funding for TB from foundations,
- GFATM. This is money available to GFATM, but which had not necessarily been disbursed to countries.

The 2000 survey collected data on 9% of the absolute amount of funding identified in this report. The percentages for the other sources are:

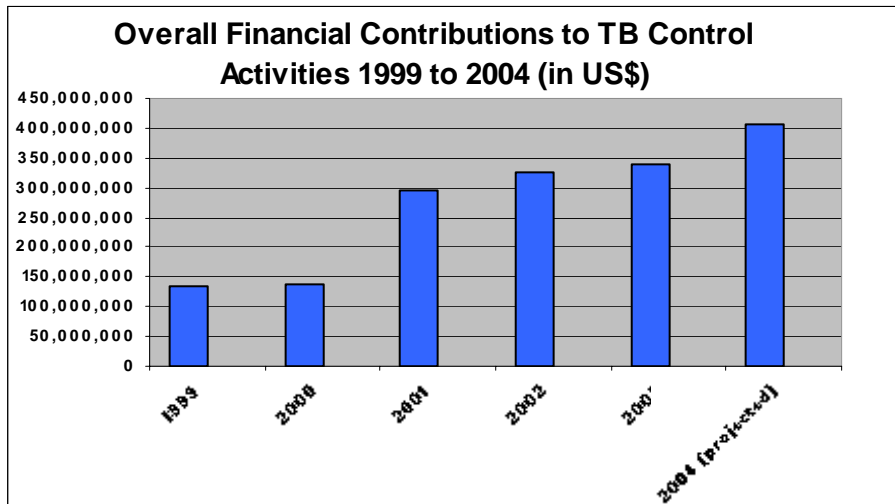
- 2004 survey – 49%
- 2003 survey of foundations – 10%
- GFATM – 32%.

Table 1: Estimated contributions in US\$ to TB control activities by development agencies, 1999-2004.

Fiscal year	Total Contributions US\$	% of total	No. of Agencies Included
1999	135,571,022	8%	17
2000	136,674,264	8%	20
2001	294,395,707	18%	12
2002	327,180,698	20%	12
2003	337,567,655	21%	10
2004 (projected)	405,592,293	25%	8
Total Overall	1,636,981,639	100%	

Sources: 2000 and 2004 surveys initiated by Stop TB Partnership; 2003 survey of funding from foundations; GFATM. Note that funding from Japan (US\$53 million in 2000-3) and Italy (US\$3.6 million in 2001-3) are not included here as the data was not available in disaggregated form. Japan's data for 1999 and 2000 is included.

Figure 1: Estimated contributions in US\$ to TB control activities by development agencies, 1999-2004



Based on Table 1.

There was a steady increase in international funding available for TB over the period 1999 to 2004. The data needs to be interpreted with some care, however, as:

- The figures understate the true picture because of missing responses from a few key agencies to the 2004 survey.
- The number of agencies included in the analysis is not constant from year to year. Most of this is due to a real change in the number of agencies involved in TB funding, but there are also gaps in the responses.
- As explained above, the sum for GFATM reflects available funding, rather than in-country spending.
- Some agencies pointed out that there may be an under-estimate of funding for TB as part of emergency relief operations. Such funding is often not broken down into disease-specific categories and may be provided through a different part of a development agency.
- Data from the World Bank, which represented 13% of the total funds,¹³ was for commitments to TB programmes and was not disaggregated by year. A steady stream of funds over time was assumed.

3.2 Recipients of Financial Contributions

The 2004 survey asked agencies to break down their funding according to the type of recipient, using the following categories:

Country level – TB programs of national governments. Data was collected on funding for 65 countries, including all 22 high-burden TB countries.

- **Projects and NGO** – specific TB projects and NGOs involved in specific TB programs

¹³ As noted earlier the total used excludes 2001-2003 funding from Japan and Italy.

- **Research and development (R&D)** – applied R&D in TB control
- **Global activities** – contributions to GFATM, GDF and other global activities. In order to demonstrate the importance of GFATM, data on these two global initiatives are given separately below.
- **Other activities** – any other financial contributions which do not fit in the above categories.

Table 2 and Figure 2 show the breakdown of development agency expenditure by recipient type. The sources are the same as for Table 1. For GFATM, it is again important to note that the figures used show the level of funding available from GFATM.

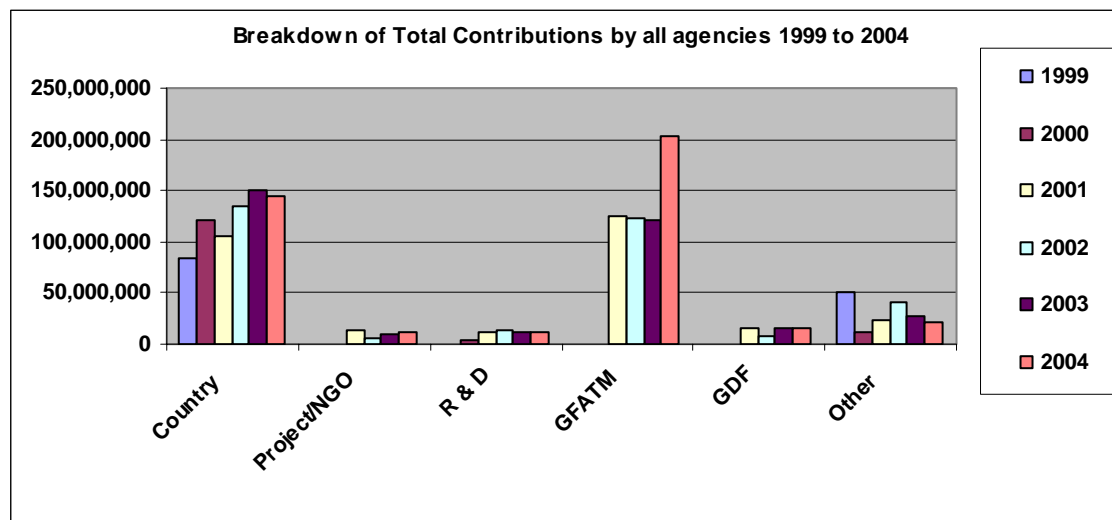
The following points can be made about Table 2:

- The majority of funding went to national TB programs – but the percentage has declined in recent years. 64% of funding at country level went to the high TB burden countries.
- The Global Fund is of substantial and growing significance in TB funding. The data suggest that GFATM funding was additional to other TB funding at least to 2003, as the amount allocated via other sources rose and then stabilized. The figure for 2004 shows an absolute decline in non-GFATM funding.
- A modest proportion (3%) of the funding was earmarked for research and development. Foundations tended to fund R&D directly and specifically, bilaterals did not. R&D funding was particularly volatile. There appears to have been a gradual decline from 2002-2004, despite a sizeable increase in the level of overall international funding for TB. This is an area where analysis of funding flows can (and should) be carried out centrally and analysed to provide a picture of funding trends.
- Funding for the category “other”, which includes funds for WHO TB activities, has been very volatile.

Table 2: Breakdown of Total Commitments, 1999-2004, in US\$

Recipient	Fiscal Year						Totals
	1999	2000	2001	2002	2003	2004	
Country	83,955,201	121,804,813	105,768,517	134,832,537	149,969,361	144,104,645	740,435,074
Project/NGO	6,800	417,000	13,747,142	5,702,121	10,457,000	11,010,000	41,340,063
R & D	726,488	3,213,669	12,018,228	14,064,629	12,031,579	11,383,579	53,438,172
GFATM	0	0	124,319,000	123,175,870	121,098,313	202,964,069	571,557,252
GDF	0	0	15,234,888	8,090,597	16,349,000	15,539,000	55,213,485
Other	50,882,533	11,238,782	23,307,932	41,314,944	27,662,401	20,591,000	174,997,592
Total							
Contributions	135,571,022	136,674,264	294,395,707	327,180,698	337,567,655	405,592,293	1,636,981,638

Sources: 2000 and 2004 surveys initiated by Stop TB Partnership; 2003 survey of funding from foundations; GFATM.

Figure 2: Breakdown of Total Commitments, 1999-2004, US\$

Based on Table 2.

3.3 Financial contributions to TB control activities by Region

The 2004 survey asked agencies to list their contributions to individual countries. For data analysis purposes, these were grouped by region. Table 3 and Figure 3 show spending disaggregated into six regions. The classification of countries by region is shown in Annex C.

In addition to the data used in Table 2, Table 3 incorporates data from the Global Drug Facility (GDF) on regional distribution of funds. The figures from GFATM are actual disbursements to TB projects in 2003 and 2004.¹⁴ Note that this is different from the information on GFATM's overall available funding used above.

Table 3 shows:

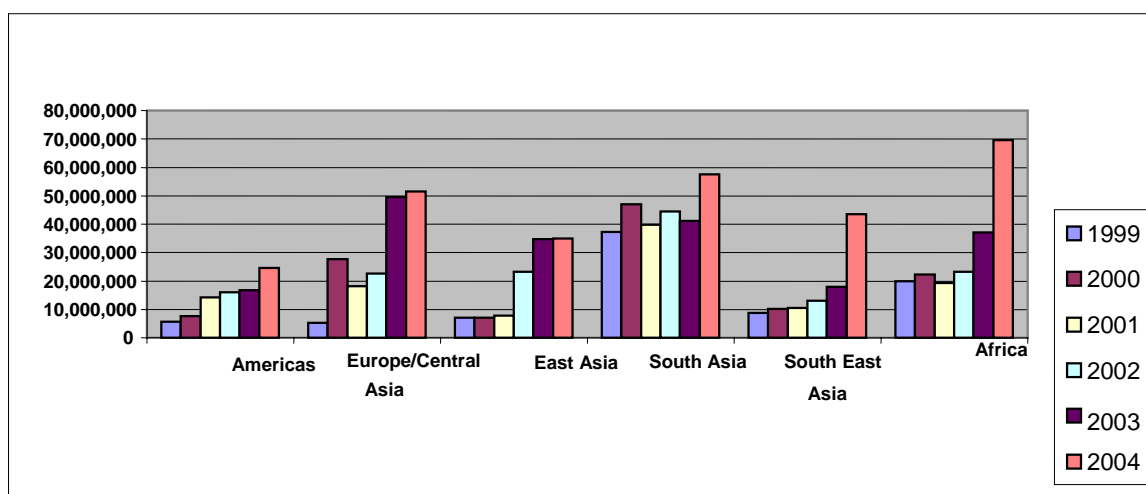
- spending grew in all regions between 1999 and 2004, with fastest growth in Eastern Europe/Central Asia (by a considerable margin).
- most regions saw a steady increase – in Eastern Europe/Central Asia and South Asia, however, funding was more volatile.
- an increase in all regions in 2004, notably Africa and South East Asia.
- the highest proportion of spending went to South Asia (which includes India). This was true overall, and for each year from 1999 to 2003. In 2004, Africa/Middle East became the largest recipient.

¹⁴ The figures for GFATM spend by region reflect disbursements made from GF to countries for TB grants, based on data in GF Progress reports for end 2003 and 2004. This is different from the commitments to GFATM from development agencies in Table 1, which represented funds available for TB. It will still overstate actual spending on TB control in country, as not all the disbursements will be spent in the year.

Table 3: Funding by region, 1999-2004, in US \$

Recipient Region	Fiscal Year						Totals	
	1999	2000	2001	2002	2003	2004		
Americas	5,605,678	7,590,568	14,293,974	16,020,152	16,694,054	24,583,603	84,788,029	9%
Eastern Europe/Central	5,274,539	27,645,338	18,097,622	22,657,719	49,522,621	51,600,071	174,797,908	19%
East Asia	7,087,500	7,087,500	7,888,935	23,252,417	34,723,373	34,856,223	114,895,947	12%
South Asia	37,184,980	47,120,007	39,803,418	44,497,638	41,249,613	57,541,707	267,397,363	29%
South East Asia	8,821,557	10,125,284	10,494,183	13,074,596	17,948,453	43,549,161	104,013,234	11%
Africa/Middle East	19,980,946	22,236,117	19,386,440	23,274,774	37,069,103	69,601,654	191,549,034	20%
Total	83,955,201	121,804,813	109,964,572	142,777,295	197,207,216	281,732,419	937,441,516	100%

Sources: 2000 and 2004 surveys initiated by Stop TB Partnership; 2003 survey of funding from foundations; GFATM – actual disbursements only; GDF data provided by Stop TB.

Figure 3: Funding by region (in US\$)

Based on Table 3

3.4 Financial contributions to TB control activities by type of agency

Table 4 shows which type of agency supports various activities. It shows marked differences among the different types of funders:

- the majority of funding earmarked for TB control activities (69%) is from bilateral donors, 21% is from multilateral agencies (namely World Bank) and 10% is from Foundations,
- of the bilaterals that submitted financial data for this survey, the USA, Canada and the UK account for 86% of funding,¹⁵
- the Global Fund was the largest recipient of bilateral funding,

¹⁵ This is the cumulative (1999 - 2004) figure for each bilateral donor taken as a proportion of the cumulative (1999 - 2004) bilateral total figure. Again data for Japan for 2001-2003 is not included; Japan is also a significant contributor but was unable to provide data in the form requested for analysis.

- the funding from Foundations is concentrated in R&D, for which they are the major funding source (86% of R&D funding identified) and “other” activities. “Other” included funds for a variety of organisation such as WHO, KNCV and Partners in Health. Foundations did not provide direct support to government control programmes and perhaps surprisingly only provided limited funding to projects and NGOs at country level.

Table 4: Breakdown of total spend by type of agency, in US\$

Type of Spend	Respondent data by Agency						Totals
	Bilateral	%	Multilateral	%	Foundation	%	
Country	397,831,328	54%	342,603,746	46%	0	0%	740,435,074
Project/NGO	39,573,385	96%	0	0%	1,766,678	4%	41,340,063
R&D	7,980,000	14%	0	0%	45,458,172	86%	53,438,172
GFATM	571,557,252	100%	0	0%	0	0%	571,557,252
GDF	53,774,485	100%	500,000	0%	939,000	0%	55,213,485
Other	66,183,644	38%	0	0%	108,813,948	62%	174,997,592
Totals	1,136,900,094	69%	343,103,746	21%	156,977,798	10%	1,636,981,638

Sources: 2000 and 2004 surveys initiated by Stop TB Partnership; 2003 survey of funding from foundations; GFATM.

3.5 Expenditures on TB in High Burden Countries

WHO has been collecting data on National TB Program budgets, funding available and total expenditures on TB since 2002. The data is presented below for total TB control expenditure among the High Burden countries. These figures include both the expenditure by the National TB Program and estimated expenditure on TB services that are not funded through the TB program (e.g. spending in clinics and hospitals). Table 5 below gives historical evolution of total TB control costs in HBC

Table 5: Estimated Total TB Control costs for High Burden Countries, 2002-2005, in US\$ millions

	2002 ^a	2003	2004	2005 ^b
1 India	61	61	83	89
2 China	61	80	120	158
3 Indonesia	22	33	45	50
4 Nigeria	11	12	16	21
5 Bangladesh	10	10	23	27
6 Pakistan	5	7	27	26
7 Ethiopia	8	11	9	9
8 Philippines	22	22	26	30
9 South Africa ^c	300	300	300	300
10 DR Congo	20	22	32	34
11 Russian Federation	245	245	399	399
12 Kenya	7	10	16	18
13 Viet Nam	24	27	29	28
14 UR Tanzania	16	15	21	21
15 Brazil	37	37	44	46
16 Uganda	2	2	5	7
17 Zimbabwe	6	6	9	15
18 Mozambique	4	4	9	9
19 Thailand	9	9	12	11
20 Afghanistan	4	4	4	3
21 Cambodia	7	6	11	12
22 Myanmar	2	2	7	6
High-burden countries	884	925	1246	1321

Sources: WHO Global TB Control - Surveillance, Planning and Financing Report 2005.

^a Costs assumed to be as for 2003 for Afghanistan, Bangladesh, Mozambique, Russian Federation, Uganda and Zimbabwe.

^b Estimate for United Republic of Tanzania is based on 2004 data, fiscal year starts in July.

^c Estimates of total TB control costs (2002-2005) for South Africa are based on costing studies and all costs are assumed to be funded by the government.

These figures suggest that there has been a rise in expected levels of expenditure on TB in all the high burden countries (apart from South Africa where data is not readily available). This increase has been particularly marked in Pakistan (five times its 2002 level), Uganda (over three times), Bangladesh, Kenya, Indonesia, Mozambique, Myanmar and China (all more than doubled). It should be noted that these are estimates based on budgets and funding available rather than actual spending and it is likely that some of this expenditure will not in fact have taken place. The reliability of estimates may also vary over time and between countries. However, there is a clear indication that there is access to increased funding at country level.

Table 6 looks at the estimates for funding available from external sources in 2005 in the High Burden Countries, as estimated by WHO. Five countries expect over 60% of the funding for TB control to come from earmarked external funding (these figures do not include external funding provided as budget or systems support) – these are Afghanistan, Myanmar, Mozambique, Ethiopia and Bangladesh).

The amount of funding per patient (in total and the part of this that comes from donors) varies widely across countries. External funding per patient ranges from less than US\$70 per patient to over US\$300.

The total contributions by high burden country for all agencies for 1999 - 2004 are in table 6a.

Table 6: Funding available from grants and loans for High Burden Countries
Estimates for 2005

	Total loans & grants available in US\$ m	Of which from GFATM in US\$ m	External funds avail as % of total TB control costs	Estimated costs of TB control per patient in US\$
Russian Fed	57	30	14%	\$ 3472
South Africa	-	-	-	-
China	39	21	25%	\$ 188
India	25	8	28%	\$ 66
Indonesia	19	15	38%	\$ 182
Brazil	2	0	4%	\$ 516
DR Congo	7	2	21%	\$ 297
Vietnam	2.9	2	11%	\$ 299
Philippines	6	2	20%	\$ 174
Bangladesh	17	8	63%	\$ 146
Pakistan	3	0	12%	\$ 213
Tanzania	5.2	0.2	24%	* \$ 320
Nigeria	3	0	14%	\$ 291
Kenya	3	3	17%	\$ 173
Zimbabwe	2	0	13%	\$ 266
Cambodia	5	1	42%	\$ 311
Thailand	2	2	18%	-
Ethiopia	6	5	67%	\$ 68
Mozambique	6.2	4	67%	\$ 311
Uganda	1.7	0.9	29%	\$ 120
Myanmar	4	3	67%	\$ 80
Afghanistan	2.7	0.7	100%	-

Source: WHO Global TB Control – Surveillance, Planning, Financing, 2002 – 2005
Data not available for South Africa. * Tanzania figure for 2004

Table 6a indicates that in that region non-HBCs have consistently received more donor contributions than HBCs. In all other regions the HBCs have received significantly more resource than non-HBCs. Overall HBCs have received more than three times the donor money than non-HBCs. The Asian region as a group (East, South-East and South) received maximum support from donors as compared to HBCs in other regions.

Table 6a: Total contributions in US\$ by high burden country for all agencies for years 1999 to 2004

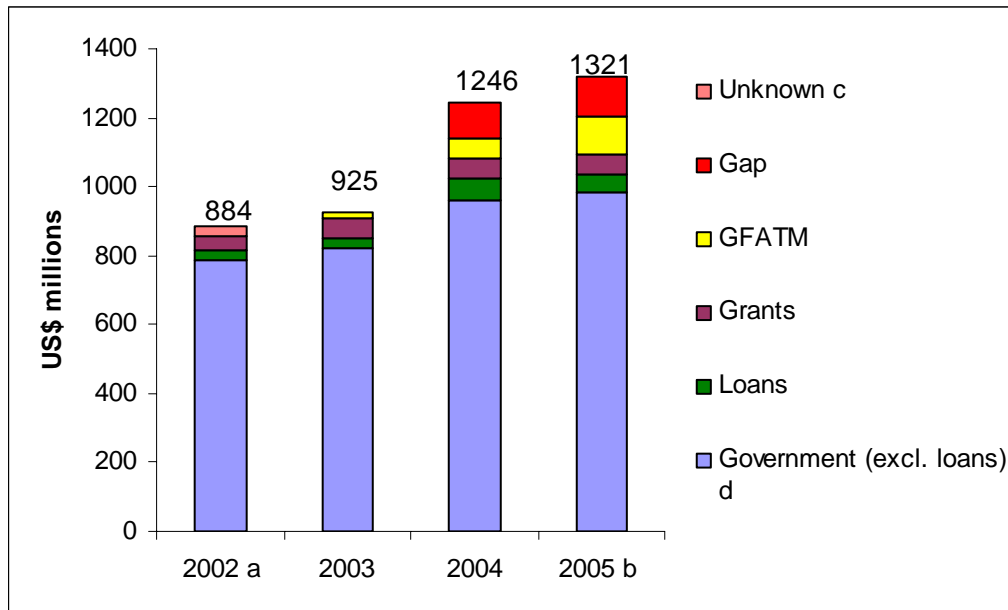
Recipient Region	Fiscal Year						Totals
	1999	2000	2001	2002	2003	2004	
Americas							
HBC	4,040,000	40,000	3,394,000	3,800,000	3,081,601	2,350,000	16,705,601
Non-HBC	1,565,678	7,550,568	10,899,974	12,220,152	10,583,901	10,880,000	53,700,273
Eastern Europe/Central Asia							
HBC	2,096,279	20,664,488	5,647,223	6,754,848	30,008,558	28,927,165	94,098,559
Non-HBC	3,178,260	6,980,850	12,345,100	15,857,200	16,950,600	12,563,100	67,875,110
East Asia							
HBC	7,087,500	7,087,500	7,116,710	23,252,417	33,086,930	34,516,672	112,147,728
Non-HBC	0	0	205,178	0	0	0	205,178
South Asia							
HBC	35,193,522	45,232,695	36,547,716	35,728,843	34,216,555	44,457,619	231,376,950
Non-HBC	1,991,459	1,887,312	3,255,703	3,775,703	3,067,440	4,091,440	18,069,055
South East Asia							
HBC	8,821,557	10,125,284	10,107,567	11,499,929	20,830,422	34,588,725	95,973,484
Non-HBC	0	0	148,341	100,505	170,897	315,548	735,292
Africa/Middle East							
HBC	13,131,684	12,435,031	8,358,239	11,819,879	21,912,097	15,000,131	82,657,061
Non-HBC	6,849,262	9,801,086	7,742,768	10,023,062	7,028,565	8,496,674	49,941,416
HBC Total	70,370,542	95,584,998	71,171,453	92,855,915	143,136,162	159,840,312	632,959,382
Non-HBC Total	13,584,659	26,219,815	34,597,064	41,976,622	37,801,403	36,346,762	190,526,324
TOTAL	83,955,201	121,804,813	105,768,517	134,832,537	180,937,565	196,187,074	823,485,707

Source: Donor Data obtained during the survey

Note: Data comprises funding for projects at country level plus GFATM funding to HBCs and non-HBC

Funding of TB control costs are depicted in Figure 4a, which clearly indicates that the bulk of financing of such costs in HBCs come from the own resources of the governments of these countries.

Figure 4a: Total TB control costs by funding source 2002-2005, 22 high-burden countries



Source: WHO Global TB Control Report– Surveillance, Planning, Financing, 2005

^a Estimates assume costs are equal to costs in 2003 for Bangladesh, Afghanistan, Mozambique and Zimbabwe.

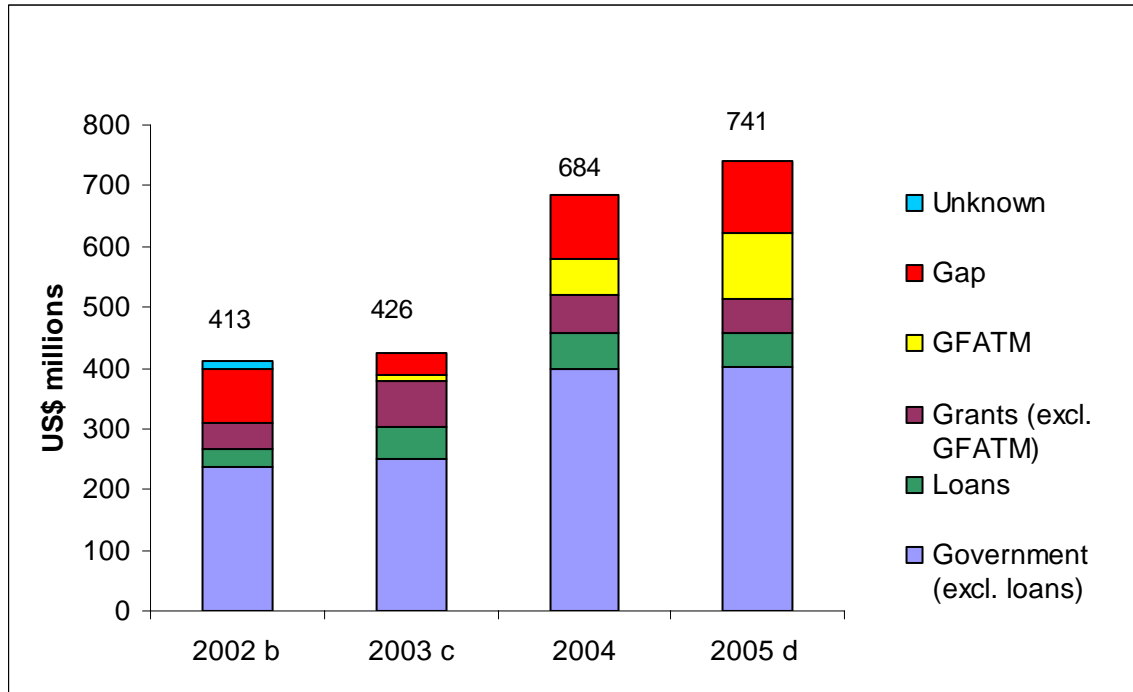
^b Estimate for United Republic of Tanzania is based on 2004 data, fiscal year starts in July.

^c "Unknown" applies to 2002 data only as breakdown of NTP budget by funding source not available in DR Congo and Nigeria.

^d Estimates of total TB control costs (2002-2005) for South Africa are based on costing studies and all costs are assumed to be funded by the government.

Fig. 4b clearly brings out that budgets for the National TB Programs in 21 of the 22 high burden countries (excluding S Africa) have increased from US\$413 million in 2002 to US\$741 million in 2005, an increase of 79%. However, this includes a funding gap of some US\$119 million in 2005.

Figure 4b: Total NTP budgets by source of funding 2002-2005, 21 a high-burden countries



Source: WHO Global TB Control Report – Surveillance, Planning, Financing, 2005

^a Data not available for South Africa.

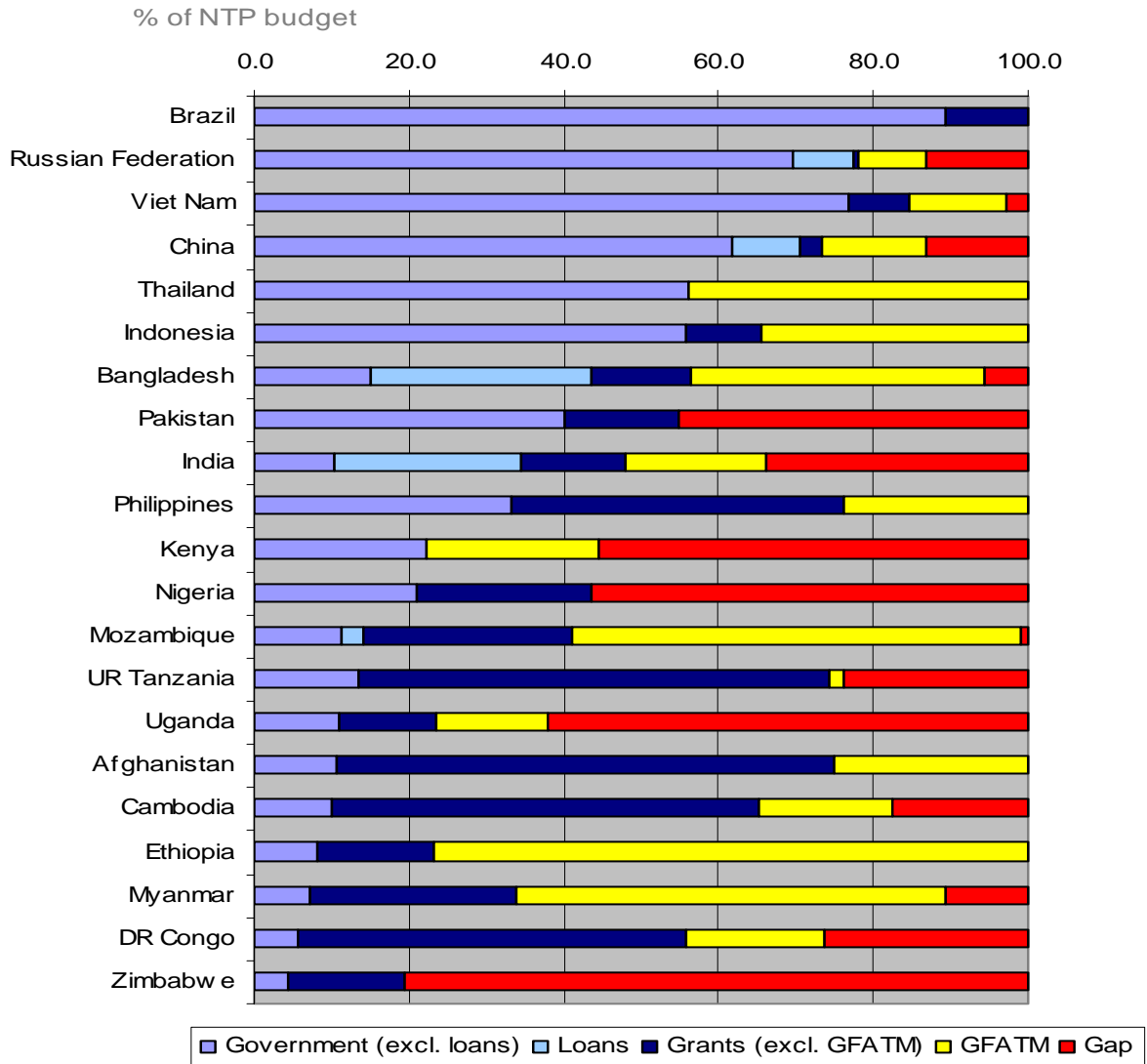
^b Estimates assume budget 2002 equal to expenditure 2002 (Ethiopia), budget 2003 (Afghanistan, Bangladesh, Mozambique and Uganda) and expenditure 2003 (Russian Federation and Zimbabwe). "Unknown" applies to DR Congo and Nigeria, as breakdown by funding so

^c Estimates assume budget 2003 equal to expenditures 2003 for Mozambique, Zimbabwe and Russian Federation.

^d Budget data for United Republic of Tanzania based on 2004 data, fiscal year starts in July.

Figure 5 indicates that all HBCs are contributing domestic resources (including loans) to meet the cost of their NTP's activities though such contributions (including loans) are below 20% in Mozambique, Cambodia, United Republic of Tanzania, Uganda, Afghanistan, Cambodia, Ethiopia, Myanmar, DR Congo; and Zimbabwe. Dependence on GFATM is clear in some of the poorest countries.

Figure 5: Sources of funding for NTP budgets, 21^a high-burden countries, 2005

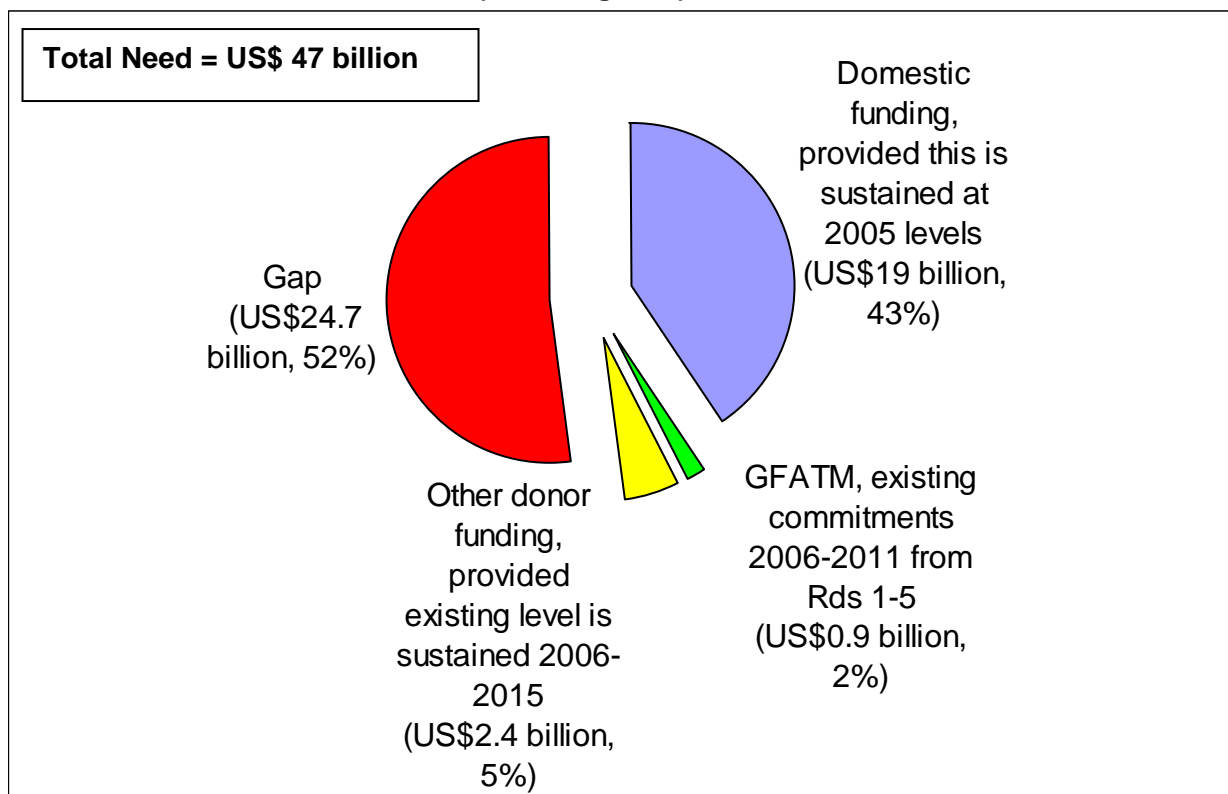


^a No breakdown available for South Africa.

Source: WHO Global TB Control Report – Surveillance, Planning, Financing, 2005

Figure 6 indicates that if the resources required for the Global Plan 2006 - 2015 (US\$56 billion) are to be raised, most of the effort will have to be made by the countries themselves, for it is improbable that the donor contribution (about US\$3.4 billion at the 2004 level) will grow more than seven fold to meet the gap (US\$24.7billion). In view of the limited capacity of the poor HBCs for raising domestic resources the need for increasing donor contributions is clear. It is also evident that such contributions should be directed more at the low income or poor countries.

Figure 6: Ten year projection of financial needs for TB control* and likely finances available if current levels are sustained (Excluding R&D)



Source: *Second Global Plan to Stop TB 2006 - 2015 (forthcoming)*

Figure 6 excludes funding requirements for new tools estimated at US\$9 billion during the Global plan period of which the current trends indicate that not more than US\$3 billion will be available. An extra effort in this direction is needed by the Stop TB Partners.

* Dots Expansion, Dots-plus, TB/HIV Collaborative activities, ACSM activities and Technical cooperation
 HLSP Institute and Stop TB Partnership Secretariat

4. Qualitative information from the questionnaires

4.1 Agency Priorities

The survey of bilateral and multilateral agencies asked:

“Are the following specifically identified as priorities for funding by your organization?”

- Health Y/N
- Communicable diseases Y/N
- TB Y/N
- HIV Y/N
- Malaria Y/N
- Poverty-alleviation programmes Y/N
- R&D for diseases such as TB and Malaria Y/N”

The following proportions of respondents replied “yes” (i.e. it *is* a specifically identified priority):

Priority	% of respondents
Health	100%
Communicable diseases	71%
TB	57%
HIV	86%
Malaria	64%
Poverty-alleviation programmes	93%
R&D for diseases such as TB and Malaria	36%

The agencies that did not identify TB as a priority per se generally said that where their emphasis is on primary health care, communicable diseases are a strong priority. They also stated that TB may be an important component of poverty alleviation programmes. In general, the multilateral development banks did not separately identify TB as a priority.

Respondents were asked whether their organization had a dedicated office or personnel dealing specifically with TB – only two replied in the affirmative. Of those respondents who commented on this, it was noted that TB often cuts across various initiatives relating to global health, AIDS and reproductive/child health.

4.2 Reasons for Funding TB

The survey questionnaire asked:

This survey aims to identify trends in TB and malaria funding and the reasons behind the trends. What factors determine the funding decisions taken by your organization in relation to TB and malaria, which the questionnaire has not already asked about? (*Examples could be political changes, or a shift in emphasis to other diseases.*)

The factors that determine TB and malaria funding decisions can be classified as follows:

The impact on poverty alleviation – 13 of the 14 respondents indicated poverty alleviation as a priority. 3 agencies specified in their responses that where poor and marginalized populations are particularly affected by TB, they were prepared to finance TB activities.

International commitments – the Millennium Development Goals (MDGs) include international targets for TB. For some agencies, their commitment to the MDGs justified their funding for TB.

Proportionality with responses to other diseases – comparisons were made with HIV/AIDS in particular. Some respondents mentioned that the priority afforded to HIV reduced funding for other diseases – including TB.

The Global Fund – GFATM is regarded as of growing importance and has become a major channel for international TB money.

Agreed country strategy – requests for assistance for TB may be specifically included in agreed country strategies for donor funding.

4.3 Support for R&D of new tools

Organizations were asked:

Would your organization consider funding for development of new tools for TB diagnosis, new drugs and vaccines? If not, what evidence and/or documentation would be needed to open a discussion on this issue?

In their responses some agencies cited their support to initiatives through a range of organizations such as the Special Programme on Research and Training in Tropical Diseases (TDR); the Global Alliance for TB Drug Development (GATBD), the European and Developing Countries Clinical Trials Partnership (EDCTP) and also GFATM. The response indicates that they expect that funding for work on development of new tools (particularly diagnostics and vaccines) will be initiated through these mechanisms/institutions. (It should be noted that not all of these channels work on developing new tools.)

In response to the second question, those agencies which responded may be prepared to finance new tools for TB control (including drugs, diagnostics and vaccines) where evidence exists of:

- favourable cost/benefit ratios
- potential added value by new tools to actual control programmes
- relevant mission and goals, as well as robust institutional arrangements, of the public private partnerships in this field.

5. The growing importance of Global Health Partnerships

The sections above have described trends in international TB funding, which reflect the fast-changing environment in aid for health. Crucial recent developments are the increase in funds for budget support and the emergence of the new Global Health Partnerships, notably the Global Fund. These wider trends have implications for TB funding and policies.

This section therefore briefly looks at wider work on Global Health Partnerships to raise issues of relevance to this paper – it draws heavily on Pearson (2004).¹⁶ Five specific issues are identified:

- I. The Global Health Partnerships appear likely to deliver **significant additional funding** for communicable diseases control, including TB.
- II. There is currently no accurate **methodology for tracking** expenditure on communicable diseases.
- III. In a very general sense, GFATM funding for TB is **well targeted**.
- IV. The availability of substantial amounts of new Global Health Partnership funding – particularly through GFATM – raises key issues about **sustainability**.
- V. The **uncertainty** of Global Health Partnership funding causes problems.

a) Significant additional funding

Pearson's concludes that the Global Health Partnerships appear likely to deliver significant additional funding for communicable diseases¹⁷ – the TB data in this report support this conclusion.

This increase in international funding for communicable diseases is occurring against a backdrop of strong growth in development assistance for health in general. This growth has been sustained over the last three decades and has seen significant increases in real development agency spending on health and population of the order of 3% per annum since 1975. Development agency support for health has increased rapidly as a proportion of overall development assistance, as the latter stagnated in the 1990s and is only now beginning to increase again. The fact that overall development assistance flows are also increasing again – by 7% between 2001 and 2002 and a further 4% between 2002 and 2003 – bodes well for the future funding for communicable diseases control.

Although there currently appears to be additional, new money for TB, there is no room for complacency. It is important to regularly monitor what is happening in terms of actual spending within countries – information from agencies can mask problems with disbursement and absorptive capacity.

¹⁶ This section draws heavily on Caines, K et al (2004). *Assessing the Impact of Global Health Partnerships*, DFID Health Resource Centre. http://www.dfidhealthrc.org/shared/know_the/publications.html#ghp This review consists of a synthesis report and 7 individual papers. Of particular relevance to this report is Pearson, M. *Study Paper 2: Economic and Financial Aspects of the Global Health Partnership*.

¹⁷ Pearson, M. (2004). *Economic and Financial Aspects of the Global Health Partnerships*. DFID Health Resource Centre. Pages 4-5.

b) Methodology for tracking expenditure

The previous paragraph describes the importance of tracking expenditure on TB. To do this requires a shift from surveys of development agencies towards data on national expenditure.

This report describes the many methodological problems encountered with a survey of development agencies – including incomplete responses and the fact that many agencies provide general budget support which does not earmark funds for particular activities such as TB control. As TB funding changes in its nature, new expenditure tracking tools need to be developed.¹⁸ One option is to invest in improved National Health Accounts, and to seek stronger, more disaggregated data about spending on individual diseases.

The Global Health Resource Tracking Working Group, convened by the Centre for Global Development, is taking forward work on improved expenditure tracking, focussing on support to national governments. This topic has been identified as a priority by the High Level Forum (HLF) on the Health Millennium Development Goals¹⁹ – the conclusions of the Working Group will be considered by the HLF in November 2005 meeting.

c) GFATM funding for TB is well targeted

In his review of the economic aspects of Global Health Partnerships, Pearson argues that, in broad terms, GFATM funding for TB is well-targeted. A number of justifications are given for this:

- TB causes a major burden of **ill health**.
- There are potentially **cost-effective interventions** related to TB. (The extent to which the potential is translated into reality depends on a number of factors, including health system capacity.)
- Allocations by Global Health Partnerships appear to be more focused on poorer countries than recent trends in overall donor assistance for health and population. Pearson uses allocations to Africa (see next bullet) and national income status as crude measures of whether allocations were “**pro-poor**”. He concludes that GFATM’s grants for malaria and TB are more pro-poor than recent allocations for infectious diseases from development assistance in general. This is true even though GFATM provides some support to higher-income countries.²⁰
- The question of equity was addressed by asking whether **Africa** is receiving its “fair” share of funding from the Global Health Partnerships. In other words, does Africa receive a proportion of the funds similar to its proportion of the global burden of disease? Table 7 addresses this issue. For TB, Africa is indeed receiving its fair share – in fact rather more. 26.2% of the global TB burden is in Africa, which received 31.6% of GFATM’s TB allocations.²¹

¹⁸ In general, DAC data from the OECD are the best means of tracking development assistance flows, but suffer from a number of significant weaknesses. (I.e. the data from the Development Co-operation Directorate of the Organization for Economic Co-operation and Development.) The situation for information on TB is better than for most diseases because of data provided in the annual WHO report *Global tuberculosis control - surveillance, planning, financing*.

¹⁹ See for example, High-level Forum on the Health MDGs (2004). *Tracking resources for global health: progress toward a policy-responsive system*. <http://www.hlfhealthmdgs.org/Documents/TrackingResources-Final.pdf>

²⁰ Pearson, *Op. cit.* Page 15.

²¹ Pearson, *Op. cit.* Page 16.

Table 7: Africa - Burden of disease and Global Health Partnership Funding

	% Burden of Disease in Africa	% Funding from Relevant Global Health Partnership going to Africa
Infectious and parasitic diseases	54.6	n/a
Tuberculosis	26.2	31.6% (GFATM)
HIV/AIDS	82.9	61.0% (GFATM) and 91% of HIV-TB combined funding
Childhood diseases	47.1	65.0% (GAVI)
Malaria	81.9	78.4% (GFATM)
Poliomyelitis	16.2	29.3% (Global Polio Eradication Initiative)
Meningitis	36.8	See GAVI
Hepatitis	42.0	See GAVI
Tropical diseases	54.9	n/a

Source: Pearson (2004)

It is interesting to compare Pearson's work with the findings of this report. Table 3 shows that 20% of funds went to Africa – less than Africa's 26% of the global TB burden. Is this an equity issue which the Stop TB Partnership needs to address? 2004 saw a substantial increase in the percentage of funds going to Africa – it will be interesting to monitor whether this increased proportion continues over time.

The authors accept that this interpretation of fairness is crude and that it only reflects one way of looking at the issue – for example it does not consider whether the absolute amounts going to different diseases are in any sense "fair". Nevertheless, the percentage of funding going to Africa is a crude but practical way of addressing one aspect of the equity debate.

d) Sustainability and national macro-economic stability

The availability of substantial amounts of new Global Health Partnership funding – particularly through GFATM – raises key issues about sustainability. Although money from the Global Health Partnerships is relatively minor in terms of overall public funding for health, it does significantly add to existing resource flows in a number of countries. In 13 countries, the Partnerships account for at least a 50% increase in health spending, and in 3 of these it exceeds 100% (Ethiopia, Liberia and Malawi). The issue is more extreme when funding from other health initiatives such as the World Bank's Multi-sectoral AIDS Program and the (US) President's Emergency Plan for AIDS Relief (MAP and PEPFAR) are included. Many low-income countries will have great difficulty in funding ongoing costs if Partnerships' funding for current activities ends as planned after a 5-year period. In this context of sustainability, the period 2008 to 2010 is crucial, as this is when initial GAVI and GFATM commitments end.²² This is clearly an issue for the Stop TB Partnership to monitor closely.

²² Pearson, *Op. cit.* Page 13.

e) Uncertainty

The rapid rise to prominence of the Global Health Partnerships, notably the Global Fund, offered many opportunities for new work in TB. However, it also produced a number of uncertainties:

- For individual countries, there has been uncertainty about if and when proposals will be approved and actually funded. In some cases (e.g. Ghana), where Government has identified Partnership-funded programs as part of its national strategies, distortions were created by non-approval of GFATM proposals.²³
- There is uncertainty about future development agency spending plans – they might increase their support to GFATM and reduce their funding to other TB-specific channels or country health programmes, or they might increase funding to all these funding mechanisms.
- Future levels of funding for GFATM are uncertain. In order to illustrate how this might affect TB funding, two scenarios were considered – funding levels if GFATM was not replenished beyond existing pledges (the 'low case') and funding levels if GFATM achieved the proposed 'steady state' stabilising at about US\$3.3 billion per year.²⁴ The total pledged for 2007 at the time of writing (June 2005) was US\$772 million. If 13% of this is allocated to TB, this suggests funding of US\$100 million for TB in 2007. For the more optimistic 'steady state' scenario, 13% of the US\$3.3 billion to be disbursed in 2007 would mean US\$429 million for TB, a substantial increase on current levels.

The sustainability of TB-related activities will crucially depend on donor decisions on GFATM, as well as whether some will continue funding earmarked for TB. A particularly important issue is funding that is and will become available for providing technical assistance. At present this appears to be volatile which is unfortunate as increasing financial support from financing Agencies like GFATM can not be used with much benefit in most countries without funding for technical assistance that is vitally needed if the TB control programmes are to succeed.

²³ Pearson, *Op. cit.* Page 18.

²⁴ See November 2004 GFATM Board Paper GF/B9/5, page 4.

6. Conclusions and recommendations

Conclusions from the data

The data presented in Sections 3 and 4 showed:

- Levels of funding earmarked for TB rose substantially and consistently from 1999 to 2004, reaching US\$405 million in 2004 (Table 1). The figures indicate that the GFATM mobilized additional funds for TB – however the figures used are for funds available to GFATM, not money actually disbursed. It will be important to ensure that there is capacity to absorb and utilise the funds.
- The majority of international TB funding for 1999-2004 was allocated to country level, with a rising share allocated through global channels (particularly GFATM).
- Spending grew in all regions between 1999 and 2004. All regions saw an increase in 2004, notably Africa and South-East Asia.
- Funding available for TB has increased at country level in all the High Burden Countries between 2002 and 2005 (except South Africa where data is not available), with funding available doubling in six countries and two where it increased more than threefold. Again this is based on funding available rather than actual expenditure which is likely to be lower.
- The majority of funding for TB identified in the surveys came from bilateral donors, with about one fifth from multilaterals. 10% was provided by foundations.
- Foundations tended to fund R&D directly and specifically, bilaterals did not.
- Half the development agencies that responded to the survey identified TB as a priority – either specifically, or as part of wider disease control or poverty alleviation work. For some, their interest in TB related to its importance in poverty reduction and contributing to the MDGs. TB as a priority did not necessarily mean high funding for TB-specific activities – some agencies concentrated on more general types of funding.

Changes in aid modalities make it difficult to identify the extent to which development agencies are funding TB activities. The move to SWAs and budget support, plus the emergence of GFATM and other global initiatives, mean that much donor support is not earmarked for TB. Some survey respondents found it impossible to isolate funding for TB from their funding for health generally or budget support. Other agencies did not respond to the survey at all. Although these issues had been anticipated from the start of the work, and discussed during the development of the approach, the number of respondents was still lower than some had anticipated. For future assessment of the adequacy of funding for TB activities, it is concluded that it would be useful to focus on funding reaching TB activities at country level, and how much is being deployed for research and development.

Recommendations

1. Changing funding modalities have meant that this survey has had a limited response to its questions on TB-specific funding. Increasingly, development agencies favour general budget support, which sees funding for a pre-agreed program of activities channelled through the recipient government's national treasury, planning, budgeting, accounting and auditing systems. In return for acceptable performance against certain criteria, the recipient government receives funding into its national consolidated accounts, which may not be earmarked for the health sector, let alone for disease-specific interventions.

In order to have a clearer picture of TB funding, it is necessary to review what is happening at country level. Possible ways of systematizing this work include:

- Identifying some “tracker” or sentinel countries, where data on actual expenditures on TB from different sources was regularly analysed. Since 2002, WHO has produced an increasing amount of data on country level expenditure in the annual Global TB Control Report. This could be related to information on which agencies contributed to budget support in the country – making a link between individual donors and TB.
 - Liaising with work on National Health Accounts and ensuring that TB-specific information is collected whenever possible.
 - Involvement in the work of the Global Health Resource Tracking Working Group, convened by the Centre for Global Development.
2. As noted above, the context of international funding for TB has changed over recent years. General budget support, SWAps and Poverty Reduction Strategies have become increasingly important. It is vital that “TB people” at national, regional and global level, understand the changing development and aid environment, and know how to operate effectively within it. Work has been done on how other vertical-type programmes can adapt to the new funding environment – for example, UNFPA recently commissioned a report on how to promote Reproductive Health Commodity Security in the context of SWAps, PRSPs and Budget Support.²⁵ Materials such as this could be adapted for TB.
 3. GFATM has brought in additional funding for TB. However, its future level of funding is unclear. If the Fund is not replenished there will be major implications for the sustainability of TB control activities. This situation needs to be monitored, including whether the funding for GFATM continues to be additional to other TB funding. The period 2008 to 2010 is crucial, as this is when initial GFATM commitments end.
 4. Section 5c describes the seemingly low percentage of TB funds going to Africa, compared with its share of the global TB burden – though 2004 saw a substantial improvement. The Stop TB Partnership should further explore and address this possible equity issue.
 5. Development agencies' interest in TB is closely linked to their wider priorities of poverty reduction and achieving the MDGs. Work on resource mobilization for TB should emphasize the linkages between TB and poverty and the relevance of TB control to the MDGs.

²⁵ Reproductive Health Commodity Security and Aid Instruments, IHSD, 2004.

6. Information on funding for TB-related research and development of new tools can still usefully be collected at a central level, and trends monitored (also against those for other key diseases). Recent estimates from the Global Forum for Health Research of around US\$45 million per year for TB research, compared with US\$1.4 billion for HIV and US\$126 million for malaria.²⁶ Given the responses to the 2004 survey (that some assume that broader research initiatives and funding channels are catering for TB R&D needs) it may be appropriate to analyse how far broader research programmes are addressing TB and where there may be funding gaps.

²⁶ Global Forum for Health Research, Monitoring Financial Flows for Health Research, 2004
HLSP Institute and Stop TB Partnership Secretariat

Annex A - Stop TB Partnership Resource Mobilization Task Force Members²⁷

Francesca Boldrini	World Economic Forum
Patricia Carlevaro	Eli Lilly
Joanne Carter	RESULTS, Inc
Marcos Espinal	Stop TB Partnership
Fraser Fowler	Canadian International Development Agency
Brad Herbert	Global Fund to Fight AIDS, Tuberculosis and Malaria
Irene Koek, Chair	United States Agency for International Development
Yasuhisa Nakamura	Ministry of Health, Labour and Welfare (Japan)
Ernest Loevinsohn	Canadian International Development Agency
Mario Raviglione	World Health Organization
Nina Schwalbe	Open Society Institute
Billy Stewart	Department for International Development (UK)
Joelle Tanguy	Global Alliance for TB Drug Development
John Tracey	Proctor & Gamble
Anant Vijay, (Secretary)	Stop TB Partnership

²⁷ The Task Force was converted into an advisory group as of October 2004.

Annex B - TB Funding provided by Foundations

This table summarizes the findings of the Open Society Institute's 2003 survey - Foundations Involved in Tuberculosis (TB) Control Activities. The data given here is for 1999-2004 and the findings are included in Tables 1 to 4. The survey also collected information from 1997-8 and projections for 2005, in US\$.

	1999	2000	2001	2002	2003	2004	Total
Bill Gates Foundation	51,100,000	11,363,669	20,306,248	23,782,414	22,892,579	16,392,579	145,837,489
Open Society Institute	333,288	3,020,786	1,382,717	918,457			5,655,248
Rockefeller			4,049,850	396,215			4,446,065
Sequella Foundation		100,000					100,000
Total	51,433,288	14,484,455	25,738,815	25,097,086	22,892,579	16,392,579	156,038,802

Annex C - Classification of Countries into regions (used in Table 3)

Americas	Eastern Europe / Central Asia	East Asia	South Asia	South East Asia	Africa
Brazil	Albania	China	Bangladesh	Burma	Angola
Bolivia	Armenia	Korea	India	Cambodia	Benin
Dominican Rep.	Baltic States ²⁸		Nepal	East Timor	Botswana
Ecuador	Estonia		Pakistan	Indonesia	Burkina Faso
El Salvador	Georgia			Laos	Burundi
Haiti	Moldova			Philippines	Cameroon
Honduras	Russia			Papua New Guinea	Congo (Democratic Republic)
Nicaragua	Ukraine			Vietnam	Egypt
Mexico					Ethiopia
Panama	Afghanistan				Ghana
Peru	Kazakhstan				Kenya
	Kyrgyzstan				Lesotho
	Tajikistan				Malawi
	Turkmenistan				Morocco
	Uzbekistan				Mozambique
					Namibia
					Nigeria
					Rwanda
					Senegal
					Somalia
					South Africa
					Sudan
					Swaziland
					Tanzania
					Uganda
					Zambia
					Zimbabwe

²⁸ This classification, rather than individual countries, was used by at least one development agency.