DRAFT - GLOBAL ADVOCACY FRAMEWORK 2011: Moving Beyond Business as Usual?

Introduction

There are 1.7 million reasons every year why global TB advocacy needs a 'refresh'. Realizing the Stop TB Partnership's goal of eliminating TB as a public health problem—and, ultimately, obtaining a world free of TB—requires the cooperation, coordination and 'dynamization' of the Partnership's greatest resource: its partners around the world. The ´Global Plan to Stop TB 2011-2015: *Transforming the Fight Towards Elimination of Tuberculosis´* outlines an ambitious agenda for scaling up. It also flags a funding gap of roughly $4.2 billion per year over the next 5 years. Political commitment, backed by the financial commitments of endemic and donor countries, and other sources, is critical to global efforts to stop TB.

There are a limited number of advocacy partners working on TB resource mobilization, and the Stop TB Partnership Secretariat is trying to address multiple strategic objectives that compete for limited resources. These include mobilizing resources, starting a social movement, increasing awareness of TB among general populations in donor an endemic countries and building brand recognition. High-impact, focused advocacy is fundamental in mobilizing resources, increasing political will and driving innovation from within the Stop TB Partnership as well as reaching to outside and new contributors. In the current financial environment, resource mobilization must be the first priority.[1]

The Stop TB Partnership brings together the TB research community with those engaged in programme implementation (including those supporting country programmes with advocacy, communication and social mobilization), so that their collaboration can facilitate the rapid development and deployment of urgently needed new tools. The Partnership's seven working groups—the working groups on DOTS expansion, TB-HIV, MDR-TB, new TB drugs, new TB diagnostics, and new TB vaccines, and the Global Laboratory Initiative—are the primary drivers for coordinating activities outlined in the Global Plan to Stop TB. They also collaborate with other parts of the Partnership to create synergy and have an essential role to play in driving issue-specific advocacy efforts.

In parallel, partners active in advocacy are building a supportive political environment, advancing policy change and—most importantly, in an extremely challenging environment for global health financing—mobilizing the resources that will allow the Partnership and its individual partners to fulfil their respective mandates and ultimately achieve Global Plan objectives.

The impact of Stop TB partners' advocacy activities can be increased if partners—working within the scope of their existing unique mandates—adopt a common overarching objective, harmonize their messaging to the extent possible, and prioritize efforts and targets.

[1] Throughout this paper, the term 'resource mobilization' is understood to include influencing policy makers and people of influence over resources to create an enabling policy environment that not only mobilizes additional resources, but ensures that they are spent efficiently and effectively.

Driving greater prioritization, coordination and alignment of Stop TB Partners' global TB advocacy efforts is the core business of the Stop TB Partnership Secretariat. This document—modelled in part on 2010's one-year global advocacy framework—aims to define an approach that will facilitate greater prioritization, coordination and alignment of Stop TB Partner global TB advocacy efforts in 2011, particularly for organizations involved in resource mobilization. The document is not intended to be a work plan for all advocacy partners, nor a comprehensive itemization of Secretariat activities.

The Global Advocacy Framework 2011 at a glance

Objective:	To mobilize resources in order to close the Global Plan funding gap	
Theme:	Innovation/Transforming the fight towards elimination	
Key steps:	-Optimize the advocacy architecture -Transform the conversation -Open new avenues of engagement	
Main targets:	The United States The European Union	BRICS The Global Fund

Key objective and themes for 2011

The main advocacy **objective** for 2011 is to increase focus and coordination towards **closing the Global Plan resource gap** of US$ 21 billion between now and 2015. Given the limited human and financial resources available for TB advocacy, resource mobilization should get higher priority than awareness-raising among the general public.

Key themes for the year are innovation—proposed by the AAC and agreed by the Coordinating Board and the Advocacy Network in early 2009 and adopted for 2010–2011—and the vision of elimination[2] as an achievable goal. This new vision is made explicit by the Global Plan 2011–2015: Transforming the Fight—Towards Elimination of Tuberculosis.

World TB Day

For World TB Day 2011 we enter the second year of a two-year campaign built on the slogan *On the move against tuberculosis,* whose goal is to inspire innovation in TB research and care.

This year's campaign challenges us to look at the fight against TB in an entirely new way: that every step we take should be a step towards TB elimination.

The campaign is inspired by the ambitious new objectives and targets of the Global Plan to Stop TB 2011-2015, which was launched by the Stop TB Partnership in

[2] See messaging in Annex I

October 2010[3]. This new plan, for the first time, identifies all the research gaps that need to be filled to bring rapid TB tests, faster treatment regimens and a fully effective vaccine to market. It also shows public health programmes how to drive universal access to TB care, including how to modernize diagnostic laboratories and adopt revolutionary TB tests that have recently become available.

The campaign will focus once again on individuals around the world who have found new ways to stop TB and can serve as an inspiration to others. The idea is to recognize people who have introduced a variety of innovations in a variety of settings.

Stop TB Partnership Advocacy Architecture: Key Players

The WHO Stop TB Strategy [4] and the *Global Plan to Stop TB 2011–2015: Transforming the Fight—Towards Elimination of Tuberculosis* [5] are the guiding frameworks for action for all Stop TB partners.

The *Global Plan to Stop TB 2011–2015* is the roadmap for the achievement of the vision and mission of the Stop TB Partnership. Implementation of the plan is guided by the Stop TB Partnership Coordinating Board and carried out by Stop TB partners and the Stop TB Partnership Secretariat. The first line of TB advocacy champions in the Stop TB Partnership is the partners themselves. In addition to partners, the following structures and individuals are foundational to building successful advocacy approaches in the Stop TB Partnership:

The Advocacy Advisory Committee (AAC), established by the Stop TB Partnership Coordinating Board, was constituted in February 2009 to advise the Board and Secretariat on advocacy strategies and issues, and to help the Partnership encourage and engage the broad network of advocacy-active partners and Working Groups in order to deliver on the roadmap outlined in the Global Plan. The AAC held its third face-to-face meeting in Berlin in November 2010, at which it contributed to and agreed upon key elements of this Advocacy Framework.

The AAC also provides guidance on building and strengthening the **Advocacy Network**[6], which provides a broader forum for partners interested in global advocacy activities to engage with each other as well as with the Stop TB working groups, sharing advocacy messages, information and initiatives. The Network has a face-to-face meeting once per year and is connected by regular "open-mic" calls on topical issues in advocacy as well as through e-newsletters.

Working Groups (DOTS Expansion, TB/HIV, MDR-TB, Vaccines, Diagnostics, Drugs, and the Global Laboratory Initiative (GLI)) drive the issues specific to their group. They have focal points for advocacy, partners that carry out advocacy activities within each group, civil society representatives, and funding from the Stop TB Partnership Secretariat for activities that include advocacy.

The Stop TB Coordinating Board provides direction and leadership, helps to determine vision and targets, and has a very important role to play in creating priority

[3] A factsheet on the global plan is attached as Annex II
[4] More information at http://www.who.int/tb/strategy/stop_tb_strategy/
[5] More information at http://www.stoptb.org/global/plan/
[6] More information at http://www.stoptb.org/getinvolved/resmob/

and support for advocacy. In addition, the members of the Board serve as TB advocacy champions and spokespeople for TB - whether as participants in high-level missions or on a day to day basis.

The Stop TB Partnership Secretariat, plays a catalytic and coordinating role in TB advocacy: linking partners, gathering and sharing information, providing strategic direction for advocacy and communication activities, mobilizing resources from donors and executing the grants, leading cross-cutting activities and issues like World TB Day, engaging the corporate sector, expanding partnerships with multilaterals (e.g. GFATM, UNITAID), managing relationships with global **Stop TB Ambassadors** and the **UN Secretary-General's Special Envoy to Stop TB**, and serving as the Secretariat for both the AAC and the Advocacy Network. **The Executive Secretary** is the voice and face of the Secretariat, a driver of vision, convenor, and diplomat - and the primary advocate of the Stop TB Partnership and its partners.

The TB financing landscape: Advocacy Challenges and Opportunities

The achievement of advocacy objectives depends on the ability of the Stop TB Partnership to anticipate and manage change in the political environment. Emerging developments create either threats to advocacy plans that must be mitigated, or opportunities upon which partners can capitalize. Some relevant areas for TB advocacy in 2011 are listed below.

Financing

- Resource mobilization is crucial and now, more than ever, must be the **top priority** for advocacy: The *Global Plan* calls for US$ 47 billion between 2011 and 2015 and there is a gap for implementation and research & development of some $4.2 billion per year. The financial crisis of 2008–2009 has had, and will continue to have, a serious impact on aid flows. Recent changes in government in many donor countries are creating an even more challenging environment for global health financing.
- The Global Fund is the largest external donor to national TB programmes and is facing great difficulty with replenishments.[7] Recent negative media on isolated examples of corruption (which were identified transparently by the GF itself) are being used to justify disengagement by some donors at a time where increased support is needed. This is not a phenomenon occurring in isolation of efforts to fund the Global Plan to Stop TB - it is an issue of critical concern that all Stop TB Partners must rally behind as any funding shortfalls will have a major impact on countries' ability to sustain and scale up TB interventions.

[7] The contributions announced in October 2010 following the Third Voluntary Replenishment of the Global Fund (2011–2013) fell short of expectations (i.e. US$ 11.7 billion vs the forecasted US$ 13–20 billion), and the actual contributions will fall short of pledges now that some countries have suspended payments in the wake of negative stories in the media in January 2011, notably Germany, the Fund's third-largest donor, which has suspended at least its US$ 270 million pledge for 2011, and Sweden (US$ 85 million for 2011).

- Many historically solid and strong bilateral donors are facing domestic financial and policy environments that have had or threaten to have knock-on effects on TB funding,

    - **United States:** Is the largest bilateral donor to TB. The republican commitment to slash US$ 100 billion from the budget is putting pressure on foreign aid including global health. Best case scenarios are being built around flat-lining commitments rather than increasing them; worst case scenarios involve scaling back existing commitments, and dropping countries currently supported for TB control.

    - **Netherlands:** the new government will be rolling its current level of 0.84% of Gross National Product (GNP) for overseas development assistance (ODA), back to 0.7%; cuts to global health programs have already been made; TB is affected and prospects for increasing funding are bleak. There will be major cuts in 2011/2012 on top of the cuts already made in 2009/2010. The government is scaling back support from 33 countries to 10.

    - **United Kingdom:** The new government coalition has committed to increasing development assistance to 0.7% of GNP; at the same time, they have articulated a priority for malaria funding and a target to raise commitments to £500 million (US $807 million) per year by 2014. They have committed to cutting deaths in half in 10 of the most malaria-affected countries in the world. Flat line scenario anticipated until 2014 when government spending will accelerate.

    - **Canada:** Traditionally a strong and solid donor (i.e. GDF, TB REACH, etc) but the new policy platform announced at the G8 in Toronto in 2010 puts a major emphasis on Maternal and Child Health (MCH). Increased effort will be required to keep TB high on the radar of key decision makers and to engage new champions.

Getting the TB Advocacy House in Order: Strategies for Renovation and Renewal

TB advocacy has moved mountains over the last decade but particularly if the Stop TB Partnership is going to rapidly increase focus and effort on resource mobilization - it is time for renovation and renewal in three key areas:

We must:

1. **Optimize the advocacy architecture:** there are good examples of coordination but the Partnership should be much greater than the sum of its part(ner)s

2. **Transform the conversation:** TB messaging is not capturing the attention of people of influence and not bringing a sense of hope, inspiration, or urgency to the fight. This must change.

3. **Open new avenues of engagement**: new donors and partnerships are being brought on board and strengthened but there is a high reliance on the same traditional bilateral donors. New business development is essential.

All three strategic approaches are needed to address the significant financial gaps in the Global Plan.

1. Optimize the advocacy architecture

Effective advocacy will require a high-performance network of global TB advocates, with enhanced communication between partners and the Secretariat, greater coordination of advocacy activities, and injection of new skill sets from partners not involved in current efforts. Several steps are already being taken in this direction:

- An evaluation of the Advocacy Advisory Committee (AAC)—assessing its performance since its creation, identifying challenges to its effectiveness, and making recommendations for its improvement—is under way will be presented to the Coordinating Board at its April 2011 meeting in Washington, DC.
- A consultancy is under way on behalf of the Stop TB Partnership Secretariat to map the global TB advocacy architecture (partners, targets, issues and activities) to identify gaps and/or unnecessary duplication of efforts, and to improve overall coordination.
- New alignments are being explored, i.e. external support—including donations in kind—from private-sector marketing/communications/public relations firms.
- The Stop TB Partnership Secretariat is co-financing a Washington, DC-based Stop TB Advocacy Officer to be employed by RESULTS, thus boosting North America-based advocacy and extending the Secretariat's geographical reach and coordination capacity.
- The Advocacy Network and AAC met in Berlin in November 2010 and discussed specific ways to reinvigorate the Network and improve its effectiveness, including better defining its role (i.e. to focus on resource mobilization) Their advocacy recommendations to the Chair of the Stop TB Coordinating Board is attached in Annex III)
- The role of VIPs and ambassadors is a potential force-multiplier for advocacy efforts focusing on mobilizing political will and resources. Some, given their profiles, are better suited to mass communication targeting general audiences for the purposes of awareness raising; others have more influence with those in positions of power and control over resource allocation. At present, they are being used for both objectives - however, celebrities are being used more for awareness raising among the lay public. The extent to which the Stop TB Partnership Secretariat, and other Partners who manage TB ambassadors, are using this key piece of the advocacy architecture effectively with the ultimate aim of resource mobilization needs a closer look. Ambassadors must be selected carefully with a prime objective in mind and a clear-headed analysis of their commitment, strengths, and weaknesses.
- The critical role of Working Groups in advancing issue-specific advocacy needs to be highlighted. Some have given considerable emphasis and attention to this aspect, while others need support to build and harness advocacy capacity internally. Overall the impact of Working Group advocacy could be enhanced by greater coordination (between groups and between the AAC and Working Group advocacy focal points, for example). The Stop TB Partnership needs its seven Working

Groups to have issue-specific advocacy as a strong aspect of their core business. The Secretariat should catalyze and support their efforts where possible while coordinating across the Working Groups on cross-cutting issues, and with other mechanisms such as the Advocacy Advisory Committee, Advocacy Network, and with Partnership VIPs / Ambassadors etc.

- Finally, the Stop TB Partnership Secretariat must look in the mirror and honestly assess its capacity to catalyse, coordinate and facilitate effectively given its limited number of staff focused on advocacy at present.

2. Transform the conversation

- At a time when the world's attention is focused on the financial crisis, widespread conflicts and environmental catastrophe, it is more difficult than ever to inspire outrage over the devastation caused by TB all over the world.[8]
- Of the three major global infectious disease killers—HIV/AIDS, TB and malaria—TB is garnering the least attention among donors, governments and the broader public. In essence, the TB 'message' such as it is, is not as sharp or compelling as that of HIV, malaria, and other emerging issues. TB advocates may be able to learn from the approaches used for these diseases.

The Stop TB Partnership needs to transform the conversation the world is having about TB in order to inject a new sense of hope, urgency and inspiration into the fight. If the Stop TB Partnership and all its members are to inspire new and existing supporters, engage political champions, and mobilize resources - the TB conversation must be changed so that it is more accessible to a broader base. By empowering partners - particularly civil society - with a tangible, understandable, motivating objective - they can more effectively put pressure on governments, donors, and other organizations for progress and commitment in the fight against TB.

For a discussion paper on some of these aspects, please see Annex V: "*Transforming the Conversation the World is Having about TB: Options to Strengthen Global TB Advocacy*".

3. Open new avenues of engagement

In response to the current financial environment and competitive landscape, the Stop TB Partnership and its advocates should accelerate "new business development" in addition to maintaining existing donor support, i.e. undertaking and increasing engagement and cooperation with the corporate sector, foundations, and high-net-worth individuals, and exploring new partnerships on emerging issues. In addition to scaling-up engagement with the BRICS (described below), the Partnership will need to identify and engage champions in Gulf States as well.

A consultancy commissioned by the Stop TB Partnership Secretariat is under way to map the composition, activities and interests of the private-sector (business) constituency, including charitable foundations that are linked to corporates and support Corporate Social Responsibility projects. The resulting insight should allow the Partnership to increase the engagement of the private sector and increase and focus their contributions to the fight against TB.

[8] WHO facts on TB are included as Annex IV

Potential new partners and avenues of engagement can also be identified by exploring emerging technologies and approaches and their potential impact on TB.

Innovation: Examples of breakthrough technologies and new ways of doing business

New technologies can be used to improve access, quality, and efficiency of TB services, and open the door to new partnerships and new resource-mobilization opportunities. E.g.:

- GeneXpert[9], a new and novel rapid test endorsed by WHO in December 2010 uses modern DNA technology to provide an accurate diagnosis for many patients in only about 100 minutes, compared to up to three months for current tests. Co-developer FIND (the Foundation for Innovative New Diagnostics) and manufacturer Cepheid have agreed on a 75% price reduction for countries most affected by TB. Of crucial importance is that GeneXpert is being adapted to also perform viral load tests for people living with HIV/AIDS (PLWHA), as well as test for sexually transmitted diseases. The evolution of this diagnostic platform towards a 'one-stop shop' approach has major implications for increasing the effectiveness of existing resources and increasing access for people.
- E-health and m-health interventions (e.g. those using the internet and mobile phones) can not only improve communication, case detection, treatment adherence, etc., but also serve as compelling examples of innovation among the TB community, showing donor funds well spent and having an impact. Specific fundraising campaigns could target innovations relevant to a particular donor audience.
- While the value of social media as a tool for TB fundraising efforts has yet to be quantified, the rise of Facebook, Twitter, Flickr, YouTube and other social media cannot be ignored and their optimal use should be explored further.

Priority Advocacy Targets

While all existing and emerging donors must be targeted by advocacy for resource-mobilization—encouraging them to increase or maintain their commitments—the Advocacy Advisory Committee (AAC) and the Stop TB Partnership Secretariat have identified the following targets as having the greatest additional resource potential; ensuring that each target is well covered by Stop TB partners in a coordinated manner will help realize that potential.

1: The United States

Challenges:

- Given its bleak domestic budgetary situation and the associated risks for TB funding, the US requires focused attention: foreign aid is one of the first budget lines to come under close scrutiny in times of financial crisis. The US is a tough TB advocacy climate, but 2011 will see many US-based events offering a chance to build advocacy momentum.

[9] More information at http://www.who.int/entity/tb/laboratory/xpert_faqs.pdf

- Messaging should convey that investments in TB are effective and impact is measurable, that there are strong accountability and oversight controls in place and that cuts to funding will lead to deaths among patients. Materials should be specifically tailored to US audiences, reflect the relevant policy focuses for each specific audience, and specify a clear target amount (the "ask"). Cuts to global health will not in any way meaningfully address the budget deficit.
- Maintain the existing funding for TB/HIV specific activities from the President's Emergency Plan for AIDS Relief (PEPFAR) but ask for a greater focus on detection and treatment of TB in overall HIV care and treatment settings, with integration and decentralization of services
- Leaders and high-level champions among US leaders (both sides of Congress, USAID, CDC, State Department, etc.) should be enlisted (with the help of Coordinating Board members and Ministers of Health/Finance from endemic countries), and trained as speakers/messengers. The recent appointment of Lois Quam as the Executive Director of the Global Health Initiative presents a fresh advocacy opportunity.

Opportunities in 2011:

There are many opportunities coming up in 2001:

- World TB Day (24 March)
- Stop TB Partnership high-level mission to Washington, DC (29–30 March)
- Stop TB Partnership Coordinating Board meeting in Washington, DC (31 March–1 April): opportunity to facilitate meetings between Coordinating Board members and key US decision-makers and to organize congressional briefings/closed-door meetings.
- UN General Assembly Special Session on HIV/AIDS - TB/HIV thematic panel to be held June 8-10, 2011 in New York.
- Global Health Council Conference in Washington, DC
- 2011 IAC in Rome
- 2012 IAC in Washington, DC
- The hiring of the Washington, DC-based Stop TB Advocacy Officer (see "Optimize the advocacy architecture", above) will help facilitate coordination and build momentum among US-based advocates for these events

2: The BRICS countries: Brazil, Russia, India, China, South Africa

Challenges:

- The G20 bloc of developing nations—particularly the "BRICS" countries (Brazil, Russia, India, China, South Africa), which are among the highest TB burden countries—is an important forum for engagement and potential financing.
- Given that the majority of funds for TB control (70%) come from affected countries and given the high potential of the BRICS countries as donors, the need for enhanced advocacy efforts targeting these countries at the global, regional and country levels is critical. This BRICS offer a major intersection between efforts at country level and global strategies to increase financial contributions both domestically and internationally.
- The BRICS have an increasing capacity to both do more and invest more in terms of TB control and in research, development and deployment of new tools to stop TB.
- China in India, in particular, should be encouraged to invest more in their own TB control, which would increase funding while taking some pressure off of the Global Fund.
- It is worth noting that many resource mobilization efforts for multiple issues are targeting emerging economies like BRICS for greater investment. The GF's last replenishment raised only $88.9 million from BRIC countries - 2/3 of the amount being from Russia.
- The challenges are twofold: get BRICS countries to cover an increasing share of their domestic TB expenditure, and encourage greater regional and international support.

Opportunities in 2011:

- **Brazil:** Given Brazil's support to Lusophone African countries, and UN Secretary-General's Special Envoy for Tuberculosis - President Sampaio's access to decision makers, increased government commitment and engaging TB champions in Brazil (they will host the Olympics in 2014) is essential and will be pursued.
- **Russia:** has supported a regional project for blood safety in the Central Asian Republics (CAR) with the World Bank. Given this precedent, and the significant regional dimensions of multi-drug resistant TB spreading via migrant labour (e.g. Tajikistan - Russia), additional efforts to encourage Russian leadership and co-financing of a regional laboratory project will be pursued.
- **India:** A.R. Rahman, the famous musician, used to be a Stop TB Ambassador. Efforts should be made to re-engage him to target not only the domestic audience in India, but also to mobilize the expatriate Indian community and Indian business community. Additional support to civil society groups engaged or potentially engaged with TB should be increased.

- **China:** We are unable to announce who at this stage, however a very influential personality is likely to be named as a goodwill ambassador for TB and HIV in June 2011. This will be the most influential figure ever to be a Goodwill Ambassador for TB; and an excellent opportunity for resource mobilization both domestically, and potentially internationally.
- **South Africa:** June - Regional ministerial forum being hosted in South Africa: "Eliminating TB in Miners in Four SADC Countries", bringing together ministers of health, labour and natural resources from Lesotho, Swaziland and South Africa, as well as the corporate sector to identify regional solutions to TB, MDR-TB and TB/HIV in the mining sector.

3: The European Union

Challenges:

- The Poverty Related Disease project faces high levels of competition in the EU's seventh and eighth Framework Programmes for Research and Technological Development and Demonstration. Advocacy should highlight the importance of TB research. An existing target (stated in the implementation plan for the Memorandum of Understanding[10] signed in July 2010 by the Stop TB Partnership and UNAIDS) is a 20% increase in research investment in new tools to improve TB prevention, diagnosis and treatment in people living with HIV, compared to FP7.
- Research for Non Communicable Diseases is the number one priority in G8/G20 health sector discussion and vaccines (through TBVI) has become the main TB tool supported by the EU
- Donors may divert their funding from the sixth to the fourth or fifth Millennium Development Goals.
- Negative publicity for the Global Fund may lead EU donors to reduce their pledge so that Global Fund rounds 10 and 11 are not fully funded
- There are not enough strong Civil society organizations (CSOs) in Eastern Europe
- CSOs have limited involvement in TB prevention, control and care
- Patient-centered approaches are not fully established in most high MDR-TB burden countries and there is a lack of mechanisms or initiatives for community-based treatment
- Languages barriers in WHO Europe region
- The mandate of the Directorate General for Health and Consumer Affairs is limited to 27 Member States

Opportunities in 2011

- Possible joint missions of existing European-level champions: UN Secretary-General's Special Envoy President J. Sampaio and WHO Regional Director S. Jakab

[10] More information at http://www.stoptb.org/news/stories/2010/ns10_045.asp

- The launch of the WHO EURO action plan on MDR-TB
- TB Childhood event in Stockholm 17-18 March and World TB day events
- Input to the public consultation on the next EU Framework Programme (FP8) by 20 May and the High Level Event on Research on 10 June
- Enhance engagement with the European Parliament Working Group on Innovation, Access to Medicines and Poverty Related Diseases
- A new European Programme for Action Against HIV, TB and Malaria will be discussed in 2011
- MDG 6 event in Moscow and UN General Assembly event in June
- Creating a steering group to follow up on the Berlin Declaration
- Integrating TB into the agenda of the HIV/AIDS European Forum
- A new diagnostic test (Gene Xpert) which has been endorsed by WHO needs to be scaled up as a key weapon in the fight against MDR-TB

4: The Global Fund

Advocacy efforts are needed both on behalf of the Global Fund, for replenishment purposes, and to strengthen financing and support for TB within the Fund.

Challenges:

- Rolling out innovation: positioning Gene Xpert as a game changer on TB and the Global Fund as the most important funding mechanism for its global roll-out
- Eligibility issues affecting MDR-TB funding, specifically in middle income countries with pockets of MDR-TB. Including TB in the most at risk populations funding channel will be one avenue to source Global Fund funding for MDR TB
- Supporting the TB applicants in the second wave of National Strategy Applications
- Publicizing TB's contribution to the Global Fund's key impact indicators (such as lives saved) and engaging potential champions among Global Fund Board members. Of the 7 million lives the GF reports are saved through GF grants, over half are due to TB investments. If the GF aims to triple the number of lives it is saving 2011-2016, it is important that the Stop TB Partnership can demonstrate the contribution to this total that could be made via increased TB financing.
- Strengthening TB advocates' engagement in Global Fund Country Coordinating Mechanisms (CCMs)
- Increasing TB advocates' and civil society's engagement in TB proposal development at country level, especially ensuring final proposal drafts are

country tailored and include appropriate and developed Advocacy Communication and Social Mobilization components

Opportunities in 2011

- Increasing the success rate and volume of TB proposals increase at round 11 by, for example, strengthening ACSM components, focusing on Gene Xpert and laboratory expansion, addressing concerns around approving MDR-TB components and strengthening TB in Prisons components of proposals
- Better proposal development through scaling up technical assistance resources, more harmonized support and providing influential Stop TB Partners and Coordinating Board members with timely information and talking points
- Global Fund secretariat to become more vocal and nuanced about the fund's impact on TB, cost effectiveness of TB programmes and lives saved
- Learning from TB REACH first wave grants to feed into Round 11 proposal development
- A clear strategy on how the Global Fund, as the mechanism with the largest purchasing power for TB, will—in a large part—fund and support the coordination of the roll-out of Gene Xpert globally.

5: Gulf States

Challenges in 2011

- Unrest in the Middle East could see governments and other Gulf donors increase investment for domestic development rather than foreign assistance

Opportunities in 2011

- Oil rich Middle East countries, particularly members of the Gulf Cooperation Council (GCC) offer good opportunities to expand the resource base for tuberculosis care. Though largely untapped for tuberculosis, these countries have had history of investing in international health.
- The UAE has provided funds for malaria, Kuwaiti NGOs have secured and distributed anti TB medicines and Saudi Arabia has supported the Global Fund.
- Despite low levels of TB in GCC countries, these states depend on an expatriate work force from tuberculosis high burden countries including India, Bangladesh, Pakistan and the Philippines. This could spark interest among GCC policy makers to finance work tackling TB
- Funding from GCC countries for tuberculosis care in poor Muslim populations could be increased
- The Stop Tuberculosis Partnership will explore and seek to cultivate potential donors from GCC states, for example The Islamic Development Bank (Jeddah), Alwaleed Foundation (Beirut and Riyadh); Sheikh Zayed Foundation (Abu Dhabi) and Kuwait patients society (Kuwait city) etc.

6. Corporate / Business Sector Engagement

Challenges

Corporations (and the business sector in general) play a dual role of being targets for advocacy, and being advocates themselves:

- Corporations are targets for advocacy, with the aim of increasing their investment in promising TB research, in the development of tools and technical solutions for TB, and in innovative technologies to overcome known bottlenecks of TB programmes. Besides these investments in their own core business activities, we can target corporations for financial donations or in-kind corporate resources which can be used to close the financial - or skills - gap of TB control efforts. This means that companies that already invest in employee or community health schemes can be targeted for TB funding on a broader scale. In addition, increasing the use of "corporate sector" management or financial skills in TB programmes can increase the impact and cost effectiveness of both public and private investments.

  Advocacy efforts can target corporations directly. They can also indirectly support private sector investments by mobilizing public incentives (e.g. tax breaks) or innovative funding support facilities (e.g. FIND), that ultimately enable corporate investments in TB. The key challenge here is to direct corporate attention to the urgency of developing (or supporting the development) of new tools and technologies that solve existing TB programme bottlenecks and increase value-for-money. In order to multiply advocacy efforts, working with and through business associations, research alliances or other networks will be vital.

- Corporations can also be powerful advocates in lobbying for increased public sector support to long-term research or increased public health spending in TB. TB is known to negatively impact on business environments, in particular as many emerging markets (including the BRICS) remain heavily burdened by TB.

  The main challenge is to identify those corporate champions with a credible interest and voice in the most relevant markets, e.g. emerging economies with a high TB burden (such as the mining sector in Southern Africa).

Opportunities in 2011

2011 opportunities include:

- Bringing the corporate sector to the discussion table (with government, civil society and other stakeholders), for example in South Africa to discuss regional issues such as TB in the mining industry.

- Leveraging the voice of High Level Mission private sector delegates at UNGASS in June in New York through effective briefing, and providing opportunities for increased visibility

- Promoting corporate sector participation in High Level Missions to the US government around the Coordinating Board Meeting in March in Washington DC, adding pressure for increased public spending on TB

- Increasing the visibility of private sector innovation in TB in various regional and global Mobile Technology and Mobile Health congresses (mHealth Alliance and GSMA arranges summits), thereby setting the scene for further private sector investment in TB related innovation and technologies

- Fora for research and development such as the High-level TB Research Movement meeting at the Rockefeller Foundation Bellagio Center in March 2011 and the Worsld TB Day Symposium: "The fight against tuberculosis: what's new in research?" supported by the Gulbenkian Foundation in Paris

- Showcasing private sector efforts to combat TB at global events such as UN Global Compact Leaders Forum (June, New York), the Global Fund Partnership Forum (June, Sao Paolo), WEF annual meetings, the Business for Social Responsibility conference (November, San Francisco)

- Innovative financing aspects must be pursued given the potential impact of a financial transaction tax.

Priority issues

In addition to ongoing advocacy carried out by individual partners, working groups, and the Secretariat, Stop TB partners should aim to facilitate the additional critical activities listed for the key issues and priority targets listed below.

1. Research:

- Advocacy should target policy-makers and donors to increase their awareness of, and support for, the Stop TB Research Movement and its basic research priorities and the associated funding needs.
- Messaging should focus on the fact that research and innovation—and the associated funding—are essential for eliminating TB.
- 2011 opportunities include:
    - High-level TB Research Movement meeting at the Rockefeller Foundation Bellagio Center in March 2011 - March 16-17
    - Launch of TB Research Roadmap 2011–2050
    - Release of Treatment Action Group (TAG) 2011 TB Research Funding figures, which represents an opportunity to develop messaging around the findings and approach policy-makers
    - The European Union's eighth Framework Programme for Research and Technological Development and Demonstration (FP8)—which will cover 2014–2020—is currently being developed, with the Commission's initial proposal expected in 2011; advocacy should highlight the importance of TB research. An existing target (stated in the implementation plan for the

Memorandum of Understanding [11] signed in July 2010 by the Stop TB Partnership and UNAIDS) is a 20% increase in research investment in new tools to improve TB prevention, diagnosis and treatment in people living with HIV, compared to PF7.

2: The TB/HIV co-epidemic:

- People living with HIV are up to 37 times more likely to develop TB during their lifetimes people who are HIV-negative
- In some countries in southern and eastern Africa, more than 50% of TB patients are estimated to be infected with HIV
- An estimated 0.4 million HIV-positive people died of TB in 2009, equivalent to about one in four of the deaths that occur among HIV-positive people each year
- The *Global Plan* sets a target of HIV testing for almost 30 million TB patients, around 4 million HIV-positive TB patients enrolled on both cotrimoxazole preventive treatment (to prevent TB and other infections) and antiretroviral therapy, and screening for TB of approximately 71 million people living with HIV
- 2011 opportunities include:
    - The TB/HIV thematic panel to be held in June 2011 in the context of the UN General Assembly Special Session on HIV/AIDS
    - Activities taking place in the context of the Memorandum of Understanding between Stop TB and UNAIDS, for example joint high-level missions to high-burden countries
    - 6th International HIV/AIDS Conference, HIV Pathogenesis and Treatment, 17-20 July, Rome, Italy – and prep for AIDS Conference, July 2012, Washington DC
    - World AIDS Day, 1 December

MDR-TB:

- Multidrug-resistant TB and extensively drug-resistant TB (MDR-TB and XDR-TB) are major threats to TB control, with all countries at risk. The highest proportion of MDR-TB cases is in eastern Europe and central Asia, while around half of the world's cases of MDR-TB occur in China and India.
- WHO estimates that in 2008, 440 000 MDR-TB cases emerged and 150 000 deaths were caused by MDR-TB. In some settings, over a quarter of all new TB patients are being diagnosed with MDR-TB.
- As of August 2010, 59 countries had reported at least one case of XDR-TB.
- Scaling up the diagnosis and effective treatment of MDR-TB is a clear priority.
- The Global Plan states the total cost of implementing the MDR- and XDR-

[11] More information at http://www.stoptb.org/news/stories/2010/ns10_045.asp

TB components as US$ 7.1 billion for 2011–2015, representing 15% of the total implementation cost.

- If the necessary funding is mobilized, around 7 million people will be tested for MDR-TB, with 1 million confirmed cases of MDR-TB diagnosed and treated according to international guidelines.
- 2011 opportunities include:
  - Launch of WHO EURO action plan on MDR-TB, covering 53 countries (will require resource mobilization for implementation)
  - Launch of WHO MDR-TB report (March 2011)
  - Announcement of a high-profile new champion for MDR-TB from a high-burden country
  - Advocacy activity promoting GeneXpert.
  - MDR-TB advocacy strategy

Issue-Specific Advocacy: The Working Groups' Advocacy Perspective

The following sections outline how each WG is approaching advocacy in 2011; their outlook, main targets, key challenges, and upcoming opportunities**.** Inputs are still being finalized by some groups.

The DRAFT table that follows shows the current finding gap by component of the Global Plan 2011-15 in (US $ billions).

		Scenario 1. Domestic funding for Implementation maintained at 2010 levels[a]	
	Implementation		
A.	Funding required	36.9	
	DOTS (excluding lab component)	22.6	
	MDR-TB (excluding lab component)	7.1	
	TB/HIV	2.8	
	Laboratory strengthening	4.0	
	Technical assistance	0.4	
B.	Funding available	24.0	
	DOTS (excluding lab component)	20.2	
	MDR-TB (excluding lab component)	2.7	
	TB/HIV	0.3	
	Laboratory strengthening	0.8	
	Technical assistance	*n/a*	
D.	Funding gap (A-B-C) in absolute $ and as a % of funding required	12.8	
	DOTS (excluding lab component)	2.4	11%
	MDR-TB (excluding lab component)	4.4	62%
	TB/HIV	2.6	91%
	Laboratory strengthening	3.1	79%
	Technical assistance	*n/a*	
	Research and Development		
E.	Funding required	9.8	
	Fundamental research	2.1	
	New vaccines	1.9	
	New diagnostics	1.7	
	New drugs	3.7	
	Operational research	0.4	
F.	Funding available if 2009 levels maintained[b]	3.5	
	Fundamental research	1.1	
	New vaccines	0.7	
	New diagnostics	0.3	
	New drugs	1.2	
	Operational research	0.3	
G.	Funding gap (E-F) absolute $ and as a % of funding required	6.4	
	Fundamental research	1.1	50%
	New vaccines	1.2	65%
	New diagnostics	1.5	85%
	New drugs	2.5	68%
	Operational research	0.1	20%
	Total funding gap	19.2	

1. Dots Expansion Working Group

We have received multiple summaries from the various subgroups of this working group. These are presented as Annex VII.

2. TB/HIV Working Group

a) 2011 advocacy activities: Advocacy for this group focuses on gaining support for

scaling up the implementation of collaborative TB/HIV activities. Key objectives for 2011 are:

- Maintain the global, regional and national visibility of TB especially among HIV stakeholders, including programme mangers, policy makers and researchers.
- Advocate for nationwide scale up of collaborative TB/HIV activities in all regions to reduce HIV associated mortality by half by 2015 (Global Plan target).
- Address the structural barriers of implementation of collaborative TB/HIV activities in Eastern Europe and Central Asia to ensure patient centred care.
- Enhance the uptake of TB/HIV research priorities especially by HIV and TB researchers.
- Promote the importance of TB among women and enhance the integration of TB and HIV services including into maternal and child health services.

b) Main targets of advocacy: All TB and HIV stakeholders including global and national programme managers and policy makers, implementers and researchers. Funding and other technical agencies working on TB and AIDS are also targeted. UNAIDS co-sponsors are particularly targeted to enhance the implementation of the UNAIDS strategy which now has TB as one of ten key areas.

c) Key advocacy challenges: There is a lack of commitment in some key organizations which should be taking a leadership role in global TB/HIV advocacy. Similarly, there is a lack of access to funding for civil society and community representatives who could carry out effective advocacy efforts.

d) Upcoming advocacy opportunities

- International Harm Reduction Association Conference, Beirut
- High Level Meeting, UNGASS, June 2011
- International AIDS Society Conference, July 2011
- World AIDS Day
- International Conference on AIDS and sexually transmitted infections in Africa 2011

3. Working Group on MDR-TB

a) 2011 advocacy activities
Pending to be agreed

b) Main targets of advocacy
Pending to be agreed

c) Key advocacy challenges
Pending to be agreed

d) Upcoming advocacy opportunities
Pending to be agreed

4. Global Laboratory Initiative Working Group

a) 2011 advocacy activities: Support is needed from the Stop TB Partnership for the development of a comprehensive advocacy strategy for the GLI**.** There is currently insufficient, time, resources and expertise with the GLI for advocacy activities.

b) Main targets of advocacy: National TB Programs, Ministry of Health, donors/funding agencies (USAID, PEPFAR, DFID, CIDA, JATA, GFATM)

c) Key advocacy challenges: The main challenges for advocacy are a lack of financial and human resources. The GLI secretariat is already stretched with the co-ordination of the GLI working group activities.

d) Upcoming advocacy opportunities: The roll-out of the Gene Xpert test presents an important advocacy opportunity and will be a key topic at various forums during 2011, including World TB day, The Union World Conference on Lung Health and the annual GLI Partners meeting.

5. New Diagnostics Working Group

a) 2011 advocacy activities: The subgroup on Community, Poverty and Advocacy has been defined within the new structure as an evolution of the past Poverty and TB Diagnostics Subgroup. The coordinator of this extended subgroup will be elected in March 2011 and a new action plan, including advocacy activities, will be defined afterwards.

6. New Drugs Working Group

a) 2011 advocacy activities:

- Participation and contribution to advocacy groups and events including the Global Health Council TB Roundtable, the World TB Events in Washington, DC, High Level Missions in conjunction with Coordinating Board Meeting, Critical Path to TB Drug Regimens (CPTR)
- Social media campaign through Linkedin Group, Facebook, Jumo, and Twitter
- Publishing of articles and interviews on the Working Group's TB R&D Blog
- Guest-publishing of articles on science and health blogs such as *Science Speaks: HIV & TB News*
- Publishing of the *Strategic Plan* document for the Working Group
- Equipping of Working Group members with materials to distribute during scientific conferences to colleagues
- Promotion of online resources and improvements to the Working Group's website
- Seeking opportunities to sponsor and partner on events and specific projects with other working groups and with groups such as the CPTR (i.e., clinical trial site landscape)

b) Main targets of advocacy

- U.S. Governmental Agencies
- Grant-making foundations and organizations that fund research and development for infectious diseases

- Consortiums and organizations who have significant resources for research and development for infectious diseases
- American and European youth
- General public

c) Key advocacy challenges

- Lack of obvious cohesive strategy from Stop TB Partnership
- Developing messages that resonate with targeted groups
- Identifying the most effective media to focus advocacy efforts

d) Upcoming advocacy opportunities

- World TB Day
- High Level Missions in conjunction with Coordinating Board Meeting
- World Health Day
- Scientific conferences [American Thoracic Society, Gordon Research Conference -- TB Drug Development, 4th International Workshop on Clinical Pharmacology of Tuberculosis Drugs, 51th Interscience Conference on Antimicrobial Agents and Chemotherapy
- 42nd Union World Conference on Lung Health
- Guest blog post in *Science Speaks: HIV & TB News*
- Partnership with the CPTR

7. New Vaccines Working Group

a) 2011 advocacy activities: The primary focus of the Working Group's advocacy activities are on raising awareness and support for new TB vaccines at the community and country level. The Working Group has established a liaison with the Advocacy Network and the Advocacy Advisory Committee, and it is expected that global advocacy will be conducted in collaboration with the Advocacy Network and the Partnership Secretariat.

Country and community level advocacy will be coordinated primarily by the Working Group's two community representatives and Aeras' advocacy staff. Planned activities include a presence at targeted national, regional and international conferences; liaising with communications and advocacy staff at TB vaccine trial sites to collaborate and coordinate efforts; developing additional advocacy materials targeted at community and country audiences; and to work with the community representatives of other Working Groups to coordinate messages, identify new opportunities and strengthen outreach efforts.

b) Main targets of advocacy: The main advocacy targets for the Working Group are at the community and country level, which include but are not limited to NGOs and civil society; government officials, policy makers and other key decision makers; community leaders and others interested in TB and global health. Global level advocacy will be done in coordination with the Partnership Secretariat.

c) Key advocacy challenges: There is general interest in and support for new TB vaccines, the progress that has been made and the potential that new TB vaccines could have on the epidemic. However, there is still not enough overall awareness of

the role for new TB vaccines or the tremendous progress that has been made over the past decade. It is also a challenge to be able to build and sustain momentum and support for a new technology that will not be available for use for several years, although that support and momentum is critical to helping us achieve the ultimate goal of a new TB vaccine. The global economic crisis makes it difficult to secure additional resources for both implementation programmes and urgently needed new technologies, including new TB vaccines.

d) Upcoming advocacy opportunities: The Working Group continues to seek opportunities for advocacy about TB and new TB vaccines at the country, regional and global levels, including the Kenya International Conference on Lung Health that is anticipated to take place in 2011 and the Union World Conference on Lung Health.

A timeline of anticipated events is included as Annex VI

Questions for reflection on the 2011 Framework:

- Is one year the right timeframe for this framework, or should it become a two or three year planning document?
- Should this framework be comprehensive, budgeted work plan for all partners involved in TB advocacy?
- Should the Partnership pool resources to aggressively pursue one or two targets per year?
- Should external support be mobilized to create a five-year resource mobilization plan for the Partnership?

Annex I: Key messages for 2011 - Prepared for WTBD

1. Everyone in the world who needs TB care should be able to get it. That is not happening now.

Proof points/secondary messages:

- A third of people with TB are not reached with accurate diagnosis and appropriate care—that's about three million people each year. Most of them are in vulnerable and marginalized groups such as prisoners, slum dwellers, migrant workers, and drug users, or are living in poverty pockets.
- Civil society, health workers and businesses need to team up to drive universal access to TB care.
- In the 21st century, no one should die from TB, a curable disease. But at least 8 million people will die unnecessarily between now and 2015 if we don't take action.

2. Investing in TB saves lives - and TB is a cost-effective investment.

Proof points/secondary messages:

- It costs on the order of just $100 to provide life-saving TB care in most developing countries.
- In 2006 the Disease Control Priorities Project counted TB treatment among the ten "best buys" in public health (DCPP, *Disease Control Priorities in Developing Countries*. 2006, Oxford University Press: New York. p. 289-309.)
- In 2009 researchers reported that countries could earn up to 10 times what they invest in TB care. (Laxminarayan, R., E. Klein, C. Dye, K. Floyd, S. Darley, O. Adeyi, *Economic Benefit of Tuberculosis Control*, in *Policy Research Working Paper Series*, W. Bank, Editor. 2007)
- In 2008 the Copenhagen Consensus ranked TB case finding and treatment fourth most cost-effective among interventions to control disease (CCC. *Copenhagen Consensus 2008*. 2008 [cited 2010 April 15]; Available from: http://www.copenhagenconsensus.com).

3. New genetic tests for TB will soon make it possible to rapidly identify everyone who needs TB treatment.

Proof points/secondary messages:

- Progress on rapid TB tests offers lots of promise, but we must also ensure that all will have access to the new test and that those who are diagnosed have access to high-quality TB care
- The diagnostic test most widely used today misses up to 60% of TB cases in people with HIV (http://www.tbevidence.org/documents/resagend/Getahun_Lancet_2007.pdf). However, the new rapid test detects TB in 94% of all cases among people living with HIV

- The new diagnostic test increases regular TB case detection by 30% and MDR-TB detection by 300%
- Greater investment in research will take us to the next critical step: a cheap, simple rapid TB test that can be used in any basic health care setting and requires little technical knowledge.
- The current treatment for TB is very long - six months or more. A new four-month treatment is on the horizon, but will only come to market if there is sufficient investment.
- We will not eliminate TB without a vaccine that is safe and effective in preventing the disease in people of all ages.

4. No one living with HIV should die from TB.

Proof points/secondary messages:

- There has been a huge investment in life-saving antiretroviral treatment, but TB takes the lives of far too many people infected with HIV and is threatening progress.
- Two million people living with HIV will die of TB between now and 2015 if we don't intensify efforts.
- All TB patients should be tested for HIV and all people in HIV care should be screened for TB. In places where TB represents a risk and all people living with HIV should be receiving preventive treatment or anti-TB drugs as appropriate.
- In June, global leaders will meet at the UN in New York to seek a way forward towards ending deaths from TB among people living with HIV.

Annex II: About the Global Plan to Stop TB 2011–2015: Factsheet

THE GLOBAL PLAN
TO STOP TB
2011–2015

Transforming the Fight
TOWARDS ELIMINATION OF TUBERCULOSIS

FAST FACTS

WHY A NEW GLOBAL PLAN TO STOP TB?

In 2006 the Stop TB Partnership launched the *Global Plan to Stop TB 2006-2015*, whose goals were twofold:

- reach the UN Millennium Development Goal of halting and beginning to reverse the epidemic by 2015
- halve TB prevalence and death rates by 2015, compared with 1990 levels.

The Partnership recognized in 2010 that there was a need to produce an updated plan that would take into account progress made since 2006 and changes in TB policy and epidemiology.

EXPECTED ACHIEVEMENTS IN TB CARE, 2011-2015

PLAN COMPONENT	BEST ESTIMATE IN MILLIONS
Laboratory strengthening	
People with drug-susceptible TB diagnosed, notified and treated	32.5
People with drug-susceptible TB successfully treated	27.9
Drug-resistant TB/laboratory strengthening	
Previously treated TB patients tested for MDR-TB *	4.5
New TB patients tested for MDR-TB	2.6
Cases of MDR-TB treated according to international guidelines	1.1
Cases of MDR-TB successfully treated	0.8
TB/HIV/laboratory strengthening	
TB patients tested for HIV	29.9
HIV-positive TB patients enrolled on cotrimoxazole	4.1
HIV-positive TB patients enrolled on antiretroviral treatment	4.0
People living with HIV screened for TB at last visit to HIV care services	71.1

* multidrug-resistant tuberculosis

WHAT'S THE SAME AND WHAT'S NEW IN THE *GLOBAL PLAN TO STOP TB 2011–2015*?

What is the same?

- Focus on 2015 targets.
- Calculation of financial requirements for both TB care and research and development up to 2015
- A guide for planning within countries
- Focus on low- and middle-income countries
- Structured according to the working groups of the Stop TB Partnership

What is new?

- **Laboratory strengthening** - included as a major component
- **Fundamental research and operational research** - goals and targets included
- Strategic frameworks to set out each major component of the plan in a clear and consistent format
- Up-to-date epidemiological projections
- Updated targets for TB care and for research and development
- Updated funding requirements

Download the complete *Global Plan to Stop TB 2011-2015* at:

www.stoptb.org

Stop TB Partnership

TB IN THE WORLD: ANNUAL IMPACT

- Each year, a total of **9 million** new cases
- More than **1 million cases** among people living with HIV
- **Half a million cases** of MDR-TB
- Nearly **2 million deaths**

2010 STATUS: ACHIEVEMENTS OF THE *GLOBAL PLAN TO STOP TB 2006-2015*

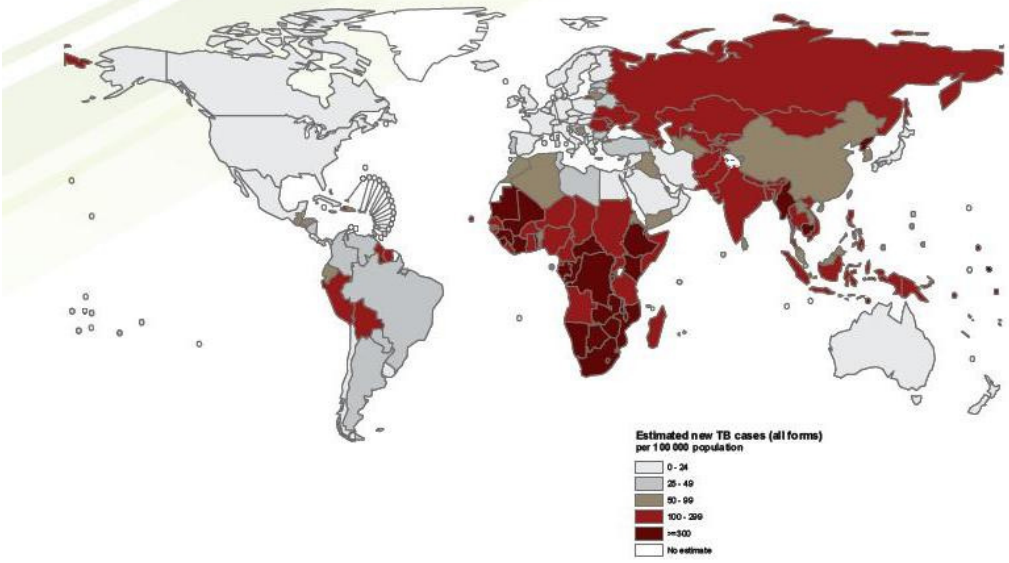
- Incidence declining slowly since peak in 2004
- **86% treatment success** rate using WHO-recommended approach
- Death rate declining since 2000
- **Stop TB Partnership target to halve death rate by 2015** compared to 1990 levels on track in Asia, the Americas and the Eastern Mediterranean

COST OF INACTION

Without dramatic increases in funding and political commitment between 2010 and 2015:

- **Over 50 million people** will develop active TB
- **Over 10 million lives** will be lost to this preventable, curable disease; 4 million of them will be women and children
- **Millions of children** will be orphaned needlessly
- **Over 2 million cases** of MDR-TB will emerge for want of proper care

ESTIMATED TB INCIDENCE BY COUNTRY, 2009



SUMMARY OF MAIN IMPLEMENTATION TARGETS

PLAN COMPONENT AND INDICATORS	BASELINE 2009	TARGET 2015
DOTS/Laboratory strengthening		
Number of cases diagnosed, notified and treated according to the DOTS approach (per year)	5.8 million	6.9 million
Treatment success rate (in annual cohort)	86%	90%
Number of countries with ≥1 laboratory with sputum smear microscopy services per 100 000 population	≥75	149
Percentage of laboratories providing sputum smear microscopy services that are using LED microscopes for diagnosis of smear-positive TB	<1%	20%
Drug-resistant TB/Laboratory strengthening		
Percentage of previously treated TB patients tested for MDR-TB	7%	100%
Percentage of new TB patients tested for MDR-TB	7%	20%
Number of countries among the 22 high burden countries (HBCs) and 27 high MDR-TB burden countries with ≥1 culture laboratory per 5 million population	18–21	36
Percentage of confirmed cases of MDR-TB enrolled on treatment according to international guidelines	36%	100%
Number of confirmed cases of MDR-TB enrolled on treatment according to international guidelines	11 000	~270 000
Treatment success rate among confirmed cases of MDR-TB	60%	≥75%
TB/HIV/Laboratory strengthening		
Percentage of acid-fast bacilli (AFB) smear-negative, newly notified TB cases screened using culture and/or molecular-based test	<1%	≥50%
Percentage of TB patients tested for HIV	26%	100%
Percentage of HIV-positive TB patients treated with co-trimoxazole therapy (CPT)	75%	100%
Percentage of HIV-positive TB patients treated with antiretroviral therapy (ART)	37%	100%
Percentage of people living with HIV attending HIV care services who were screened for TB at their last visit	~25%	100%
Percentage of people living with HIV attending HIV care services who were enrolled on isoniazid preventive treatment (IPT), among those eligible	<1%	100%
Laboratory strengthening (additional to those above)		
Percentage of national reference laboratories implementing a quality management system according to international standards	<5%	≥50%

SUMMARY OF MAIN RESEARCH AND DEVELOPMENT TARGETS

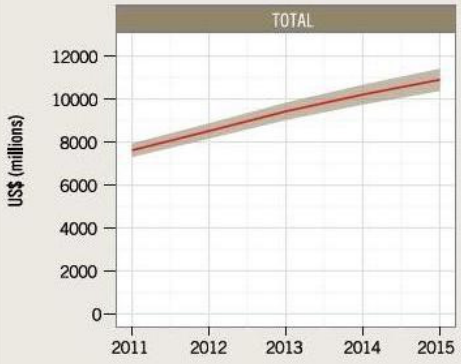
PLAN COMPONENT AND INDICATORS	BASELINE 2010	TARGET 2015
Fundamental research		
New funding for fundamental research, per year (US$ millions)	98	450
New diagnostics		
Number of new tests for the diagnosis of active TB that can be used in district laboratories	1	2
Number of new tests for the diagnosis of active TB in peripheral-level laboratories	1	2
Number of new point-of-care tests for the diagnosis of active TB in peripheral-level health centres	0	2
Number of new tests for the diagnosis of drug-resistant TB in district laboratories	0	2
Number of new tests for the diagnosis of drug-resistant TB in peripheral-level laboratories	0	1
Number of new tests for the diagnosis of drug-resistant TB in health centres	0	1
New drugs		
Number of new and/or repurposed drugs in Phase I trials	3	21
Number of single or combination Phase II trials investigating new and/or repurposed drugs	6	34
Number of new regimens for drug-susceptible TB in Phase III trials	2	3
Number of new regimens for drug-resistant TB in Phase III trials	0	2
Duration of treatment of latent TB infection	4-6 months	2-3 months
New vaccines		
Number of vaccine candidates that have entered Phase I trials	5	20
Number of vaccine candidates that have entered Phase II trials	2	9
Number of vaccine candidates that have entered Phase IIb trials	2	3
Number of vaccine candidates that have entered Phase III trials	1	4
Operational research		
New funding for operational research, per year (US$ millions)	35	86

SUMMARY OF ESTIMATED FUNDING REQUIRED TO IMPLEMENT THE GLOBAL PLAN TO STOP TB 2011–2015

PLAN COMPONENT	TOTAL FUNDING REQUIRED, US$ BILLIONS (% TOTAL)
Implementation	**36.9 (79%)**
DOTS (TB care)	22.6 (48%)
Drug-resistant TB	7.1 (15%)
TB/HIV	2.8 (6%)
Laboratory strengthening	4.0 (8%)
Technical assistance	0.4 (1%)
Research and Development	**9.8 (21%)**
Fundamental research	2.1 (5%)
New diagnostics	1.7 (4%)
New drugs	3.7 (8%)
New vaccines	1.9 (4%)
Operational research	0.4 (1%)
All components	**46.7 (100%)**

The projected funding gap for meeting all the goals and targets of the *Global Plan to Stop TB 2011-2015* is US$ 21 billion.

TOTAL FUNDING REQUIREMENTS



Stop TB Partnership

World Health Organization

THE GLOBAL PLAN TO STOP TB 2011–2015

Printed in Geneva, Switzerland

Annex III: AAC Letter of Recommendations to Chair of Stop TB Coordinating Board

TO: Professor Rifat Atun, Chair, Stop TB Partnership Coordinating Board; Stop TB Partnership Coordinating Board Members

FROM: Rachel Wilson, PATH (AAC Co-Chair), USA
Lee B Reichman, New Jersey Medical School Global Tuberculosis Institute
(AAC Co-Chair), USA
Lucy Chesire: TB Patients Representative - TB ACTION Group, Kenya
Paul Sommerfeld, Chair of TB Alert, UK
Beatrijs Stikkers, Executive Secretary, KNCV Tuberculosis Foundation,
Netherlands
Shaloo Puri Kamble, Advisor, World Economic Forum
Ahmed Al-Kabir, President, Research Training and Management (RTM)
International, Bangladesh
Ms Noriko Shirasu, Secretary General, Results Japan
Sue Perez, Treatment Action Group (TAG)

DATE: 29 November 2010

RE: Recommendations from Stop TB Partnership Advocacy Advisory Committee

As you know, the Stop TB Partnership's Advocacy Advisory Committee (AAC) was established to "advise the Board and Secretariat on advocacy strategies and to help the Partnership encourage and engage the broad network of advocacy-active Partners and Working Groups". We are writing to you following the recently concluded AAC's second annual face-to-face meeting (November 16-17) to inform you of the deliberations and recommendations that resulted from the meeting.

Advocacy goal of the Stop TB Partnership: At this time of fiscal challenge for most nations and the urgent need for increased TB support, we strongly recommend that the role of global advocacy both by the AAC and the Partnership focus on **resource mobilization** to cover the costs outlined in the updated Global Plan to Stop TB 2011-2015. A strategic approach to increasing political will and support among donors to fill financing gaps is critical and should be a top priority. During the AAC meeting, we agreed on key areas for advocacy related to resource mobilization that we recommend for consideration and discussion by the Coordinating Board:

- Increased strategic advocacy engagement with the **GFATM:** Provide those who are influential with the GFATM (including Coordinating Board members) with timely information, talking points, financial targets, and other data and materials to enhance their engagement with the GFATM on behalf of TB.
- Ensure strategic use of board members and Ministers of Health and Finance from endemic countries to encourage the engagement of **new and stronger TB champions among political leaders in the United States**, including the

engagement of communications professionals in supporting preparation for the April 2011 CB meeting and related board delegation to the US

- Invest appropriate staff and consultant support to assure that the **Southern African Ministerial forum** maximizes advocacy impact and not just event logistics. The communication around this event should be geared to global impact with policy makers and as lead-in to the TB/HIV Global Leaders Forum at the UN in June 2011.
- Promote increased coordination in the pursuit of **EU resources** for TB, particularly research for urgently needed new tools.
- Encourage increased support for advocacy aimed at resource mobilization from **high burden countries**.

In order to meet the funding goals set forth in the revised Global Plan, it is critical that **a strategic and well-orchestrated advocacy** approach be employed. Thus, we would like to offer several operational and structural recommendations:

1. Advocacy messaging: Successful advocacy requires a **bolder and more inspiring language and targets**. AAC members and the broader Advocacy Network have shown significant excitement and enthusiasm about the concept of an "*elimination phase strategy*" with a goal of "*zero TB deaths*". We recommend that advocacy communications professionals assist the Secretariat in refining, testing and packaging a new bold advocacy communications strategy. Of course, as with any messaging endeavour, it is important that the messaging be well grounded technically. This will require the full engagement of WHO.

2. Advocacy partner mapping: Stop TB partners are our most valuable advocacy asset. However, in order to assure informed and coordinated advocacy, it is important that the Secretariat understand a variety of factors about the partners involved in global advocacy, including: where they are located, who they influence, what their advocacy priorities are, and the type of advocacy they are engaged in. We recommend that a **time-limited consultancy** be pursued to collect this information from advocacy-engaged partners in the beginning of 2011. It would also be extremely helpful to engage in an additional consultation later in the year to collect information from the partners on the key advocacy successes and gaps in 2011, in order to track and inform the 2012 advocacy strategy.

3. Coordination: During our discussions, it became apparent that coordination across different players is not always maximized. We recommend that the Stop TB Partnership Secretariat seek to **increase alignment and coordination** amongst the variety of actors engaged in TB advocacy, including: the Advocacy Network, AAC, Stop TB Secretariat, WHO, as well as country level advocates through the ACSM subgroup.

4. Country advocacy: Given that the majority of funds for TB (70%) come from affected countries and the potential of the BRICS to mobilize resources for TB, the need for **enhanced country advocacy and better coordinated regional advocacy** is critical. One theme that arose several times during the Advocacy Network meeting was a feeling among country level advocates that there is a lack of sufficient support for country level resource mobilization advocacy and

monitoring. However, since the mandate of the AAC is global (i.e. donor) advocacy, we recommend that the ACSM Sub-Group seek to address these gaps with country-level advocacy partners and also ensure maximised use of available resources.

5. Staffing: As stated by the Coordinating Board at their last meeting, *advocacy must be a core function of the Stop TB Partnership*. We are deeply concerned about the very **low level of full time skilled advocacy staffing at the Secretariat**, even when all current vacancies are filled. We recommend as our highest priority, that efforts be made to sufficiently staff the advocacy team.

6. Proactive planning: When pursued reactively and in an ad-hoc manner, events are likely to be ineffective and lack impact. It is imperative to make the best use of available resources. **Proactive and strategic planning and prioritization** will maximize resources and help prevent the pull of resources to areas with minimal impact. One example of where such planning and prioritization does not seem to have been deployed in the most strategic manner is in the use of VIPs. We recommend that the selection and use of VIPs by the Secretariat be determined by *how influential the VIP will be in increasing resources from the highest target donors.* We believe that those with political influence (i.e. Ministers of Health and political leaders) will have more of an impact and be easier to utilize than celebrities. Note: The use of VIPs at country level ought not to be excluded, but should be used in such a way that their support requires only minimal time and resources from the Secretariat.

   We are very grateful to the Stop TB Partnership and to the Secretariat staff for providing this opportunity for us to engage in a strategic advisory role and we look forward to a highly productive relationship in this regard. We would be happy to discuss further, any of these or other issues at your convenience.

Annex IV: Facts about the worldwide TB burden (WHO)

Using consistent facts to support our messaging will help the TB community build credibility. Reports, factsheets and other materials are available at www.who.in/tb.

Add cost effectiveness.

- **There were 9.4 million new TB cases in 2009**
  - 3.3 million were among women.
  - 1.1 million were among people with HIV.
  - All countries are affected, but most cases (85%) occur in Africa (30%) and Asia (55%), with India and China alone accounting for 35% of all cases.
  - The total number of incident cases of TB is increasing in absolute terms, but the number of cases per capita is falling as a result of population growth. The estimated global incidence rate fell to 137 cases per 100 000 population in 2009, after peaking in 2004 at 142 cases per 100 000. The rate is still falling, but too slowly.

- **1.7 million people died from TB in 2009: 4 700 deaths per day**
  - 380 000 were women: TB is among the top three causes of death among women aged 15–44.
  - 380 000 were living with HIV.
  - The TB death rate has fallen by 35% since 1990, and the number of deaths is also declining.

- **Since 1995, 41 million people have been successfully treated and up to 6 million lives saved through DOTS and the Stop TB Strategy.**
  - 5.8 million TB cases were notified through DOTS programmes in 2009.
  - Globally, the percentage of people successfully treated peaked at 86% in 2008.

- **Of the 22 TB high-burden countries, 13 countries are on track to meet the 2015 Millennium Development Goal target.**
  - 12 countries are on track to reach the 2015 Stop TB Partnership targets.

- **1.6 million TB patients knew their HIV status in 2009**
  - In 55 countries, including 16 in Africa, at least 75% of TB patients knew their HIV status.
  - The highest HIV-testing rates among TB patients in 2009 were in Europe (86%), Africa (53%) and the Americas (41%).
  - 37% of HIV-positive TB patients were enrolled on antiretrovirals and 75% started on cotrimoxazole preventive treatment in 2009.

- **In 2010, the largest WHO MDR-TB survey reported the highest rates ever of MDR-TB.**
  - There were an estimated 440 000 new MDR-TB cases in 2008, and 150 000 deaths from MDR-TB.
  - It was estimated that in 2009, 3.3% of all new TB cases had MDR-TB.
  - Many countries have developed plans to address MDR-TB, but the response globally is still insufficient.
  - Cases of XDR-TB—which occurs when resistance to second-line drugs develops on top of MDR-TB—have been confirmed in 58 countries.

Stop TB Partnership

Annex V: Discussion paper: Transforming the Conversation

Transforming the Conversation the World is Having about TB

Options to Strengthen Global TB Advocacy

Draft Discussion paper
February 8th 2011

I. Introduction

The fight against Tuberculosis (TB) has achieved many gains in the past decade, but at present is largely failing to capture the world's imagination, inspire significant attention, or galvanize game-changing efforts to save the more than 1.7 million people that die— and those not detected—from this contagious but curable plague each year. This global 'TB attention deficit' is especially clear when compared with the compelling messaging and advocacy taking place in the fight against other diseases like malaria, HIV/AIDS, and Polio. When held up against the ascendant priorities of maternal and child health (MCH), and non-communicable diseases (NCDs), current TB messaging and advocacy approaches are in need of both transfusion and transformation.

In October, 2010 the Stop TB Coordinating Board expressed profound concern over the crisis in TB advocacy and directed the Stop TB Partnership Secretariat to develop a discussion paper examining the idea of a 'TB Elimination Phase' strategy linked to an overarching TB advocacy approach.

The purpose of this discussion paper is to further examine this concept, seeking to balance the need for compelling advocacy, with technical credibility in the approach. The ultimate goal of it is to build agreement that TB elimination should be viewed, not as a distant dream, but as a clear vision that must be approached with explainable steps.

II. Background

With nine million people becoming ill each year with TB, and with no effective vaccine available yet, few would argue that the road to elimination must be paved with obstacles. Yet there have been impressive achievements during the past decade. Millions of people are cured ever year—TB is a curable disease, and it can be cured at low cost. The percentage of the world's population becoming ill each year with TB is declining slowly and deaths are also falling gradually (roughly 40,000 per year).

Yet the stakes remain high: Each year there are more people that fall ill with TB than the year before, and without greater effort, some 8.5 million people will die of this curable disease by 2015.

The fight against TB faces a number of critical advocacy and messaging challenges:

1. **Limited Resources:** At a time when the world's attention is focused on the financial crisis, widespread conflicts and environmental catastrophe, it is more difficult than ever to inspire outrage over the devastation caused by TB all over the world - and spark action to address it. Resources and 'mind-space' are limited.

2. **Competitive advocacy environment**: Of the three major global infectious disease killers - HIV/AIDS, TB and malaria - TB is garnering the least attention among donors, governments and the broad public. Despite great progress in the last decade, the global health landscaped has changed and TB is being "out-messaged" and 'out-championed' by HIV and malaria. Yet every

20 seconds someone dies of the disease. There is a solid plan for addressing it worldwide. Yet prominence for the issue remains elusive.

3. **Too much Jargon**: TB advocacy needs to move beyond the current jargon-heavy messaging, which is scientifically correct but often obscures powerful facts by expressing them in terms of prevalence, incidence, case detection rates, treatment success rates—turning people and their very real lives into impersonal statistics. TB is being "out-messaged" and "out-championed" by, among others, HIV/AIDS ("GETTING TO ZERO") and malaria ("Zero malaria deaths by end-2015"). TB advocates should be empowered to use the type of language used by advocates for these diseases and by the Global Fund ("triple the number of lives saved 2011-2016").

4. **The MDGs are a messaging trap for TB:** The MDG target for 'halting and reversing the incidence' of TB, was reached in 2004 when the global TB epidemic began a slow decline. At a time when donors are trying to prioritize support to MDG issues like maternal and child health that need extra effort in the next 5 years to reach their goal, having reached the MDG 7 years ago is not a strong selling point in the current environment. When more people become ill with TB each year than the year before, it is difficult to communicate to the outside world why the TB community has already reached the target and why that is significant.

5. **No TB goal or targets after 2015:** While *The Global Plan to Stop TB 2011-2015*: *Transforming the Fight-Towards Elimination of Tuberculosis,* is an ambitious, comprehensive 5-year plan, it was not designed to look beyond 2015. The Stop TB Partnership has no phased, interim targets that explain how to transition to a 'TB free world' between 2015 and 2050. The year 2050, the current deadline for TB elimination, has no political relevance that would motivate increased attention or action - now.

Figure I: New targets from other disease movements

The HIV movement has called for:

- Zero discrimination
- Zero new infections
- Zero AIDS-related deaths
- Virtual elimination mother to child transmission of HIV by 2015

The malaria movement has called for the following:

- 100% of people needing a bed net will have one by 2010
- Zero malaria deaths by 2015

The TB 'conversation' must advance towards the identification of a bolder target. Whatever the target (e.g. Universal Access, elimination phase, zero TB deaths,

zero TB deaths among HIV+, campaign to save 1 million lives, etc.), these potentially galvanizing goals to the greatest extent possible, must be underpinned by a technically credible approach to achieving them.

III. 'Elimination Phase': Where technical reality and advocacy collide.

'Elimination' is a powerful word in public health. Polio, malaria, HIV and others all use it in messaging and approach to one extent or another. It captures people's imagination and support by rallying them around the possibility of investing today in order to build a significantly better world tomorrow. Consider smallpox eradication, one of the best known and frequently cited public health success stories.

In TB, elimination has been (unfortunately) defined as reducing levels to less than 1 case per million population. The reality, given the nature of the disease, is that global elimination will never possible without a vaccine. Given that limiting step, up until now, the notion of TB elimination has been pushed off into the distant future, with a target of the year 2050. The notion of elimination does not feature prominently as a goal or target that can be used to enhance advocacy now or in the foreseeable future.[12] Recent discussions around a phased approach to eliminating TB started in June 2010 with the intention of harnessing the power of the 'elimination' advocacy platform as part of the fight against TB while maintaining a more realistic approach to implementation.

The vision of a phased approach to elimination received a very positive response from the Stop TB Board in October 2010. It was based on the notion of dividing the burden of TB into different phases and determining what it would take in terms of country-specific technical interventions and resources to shift a given country one 'phase' closer to elimination. This is appealing for a number of reasons (see Box 1,2): First, it enables broader discussion around elimination—a much more powerful and understandable word than 'incidence' 'prevalence' or 'case detection'. Second, it would make measurable progress achievable in politically relevant time-frames (rather than having a goal of 2050 for elimination, which is intangible for political figures and others leaders today. Third, given the wide variance in TB burden globally, it would enable those countries (including donor countries) with medium and low burdens to accelerate attention and effort to eliminate TB domestically. The idea as presented to the Board in October is described in Box 1 and 2.

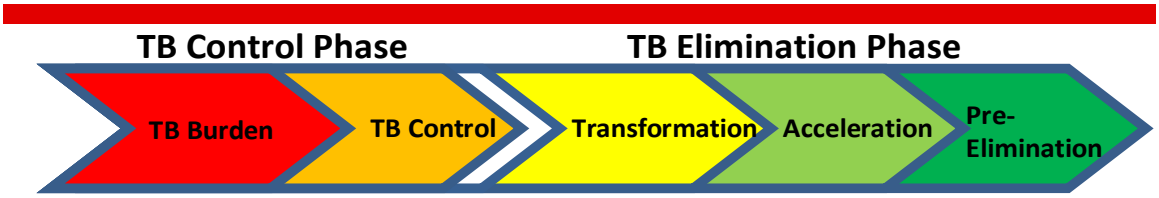
[12] This is starting to change, for example, the Global Plan 2011-2015 has as its title: "Transforming the fight - Towards Elimination"

Box 1: Slide from Coordinating Board Presentation - October 15th 2010

TB Elimination Phase Strategy 2015 - 2025
"Ending deaths from Tuberculosis"

What if we:
- Categorized all countries <100 /100,000 into different 'Elimination Phases' according to case notification rate thresholds (e.g.; Transformation, Acceleration, Pre-elimination, Elimination)
- Identified countries with potential to move from one of these Elimination Phases to another,
- Modeled the impact of full scale-up of high-impact interventions (E.g. new tools, high impact approaches) in terms of lives saved, etc.
- Developed Elimination Phase costed plans, and advocated for significantly increased funding to scale up high impact interventions moving countries toward elimination phase.

Box 2: Illustrative Slide from Coordinating Board Presentation - October 15th 2010



REGION	COUNTRY	CONTROL PHASE		ELIMINATION PHASE		
		TB Burden	Control	Transformation	Acceleration	Pre-Elimination
		>100/100,000 *	<100/100,000 *	<50/100,000 *	<20/100,000 *	<10/100,000 *
EUROPE	Albania					5
	Andorra					4
	Armenia				16	
	Austria **					
	Azerbaijan				16	
	Belarus				11	
	Belgium					3
	Bosnia and Herz				13	
	Bulgaria				13	
	Croatia					7
	Cyprus					<1
	Czech Republic					2
	Denmark					2
	Estonia				11	
	Finland					2
	France					2
	Georgia			43		

The 'Zero TB Deaths' approach. In the months following the Coordinating Board meeting, there were discussions within WHO and the Stop TB Partnership Secretariat about practical considerations and technical realities. It was recognized that some countries (in Europe, North America, Latin America and the Gulf States, for example) have very low numbers of TB cases compared with their overall populations and

could be considered in the 'pre-elimination' phase[13]. But it was felt that this approach, with the tools currently available, would not be practicable in higher-burden countries. It was agreed that whatever the potential appeal of an elimination phase strategy from an advocacy and communications viewpoint, a solid foundation of technical credibility must underlie any new effort to transform global TB advocacy.

While a TB 'Elimination Phase' approach was thought by technical experts to be impractical as a global platform at this time, a goal of 'eliminating' TB deaths, as a milestone on the way to TB Elimination, was seen as more worthy of exploration. Given the 1.7 million lives lost each year to what is a preventable and curable disease, efforts to put saving lives at the centre of the discussion may well have powerful advocacy and messaging implications around the world.

If 'Zero TB Deaths' is a milestone on the way to eliminating TB however, it should not preclude those countries in or near the 'pre-elimination phase' from pursuing elimination already.

What could 'Zero TB Deaths' look like? Aiming for zero deaths is highly compelling from an advocacy point of view. As noted earlier, Malaria has this goal for 2015, AIDS has it as well ('zero new infections, zero discrimination, zero aids-related deaths' and 'eliminate mother-to-child transmission by 2015'). A 'Zero TB Deaths' approach would be a platform for:

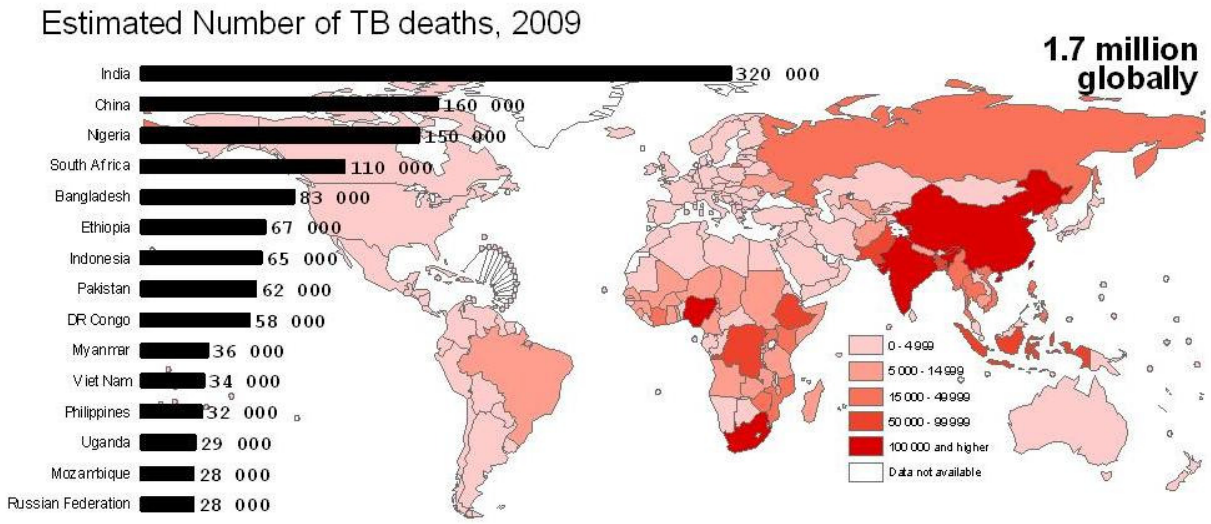
1) Bringing a renewed sense of urgency to the fight against TB,
2) Focusing additional attention on saving lives
3) Mobilizing resources (for scale up and implementation of TB care and R&D)

Defining 'Zero deaths' for TB - the technical reality

Challenge 1: what does "zero" mean? Even under the best possible clinical care conditions, at least 5% of people with TB disease who receive treatment, die. For people co-infected with HIV, roughly 30% will die and for those with MDR-TB, at least 40%. Basing the 'Zero TB Deaths' approach on technical reality therefore means defining 'Zero' as the number of lives ***it is possible*** to save. For example in the case of drug-susceptible TB in HIV-negative patients, reducing deaths by 95% would be the 'achievable' zero. There may be other considerations as well (e.g. 'zero' in a limited number of countries as the malaria approach is doing).

Challenge 2: many deaths occur among the "unreached." Every year rough 3 of the 9 million people who become ill with TB fail to access effective treatment. Many of the TB deaths occurring each year are in this population. Without a new push to reach them it will be difficult to achieve 'Zero TB deaths' in the short run. Innovation, additional effort and health systems investments all will be needed. This will take time..By targeting resources to areas of greatest TB death and scaling up the most cost-effective, high-impact interventions available it is technically feasible to save millions of additional lives.

[13] This is defined as those with TB incidence of <20 / 100,000 population



IV. Developing the approach to 'Zero TB Deaths': Three key variables (intervention, impact, and cost) need to be brought together by modeling to addressing the following question:

If areas of high TB deaths were targeted with the most high-impact interventions, (including new tools like GeneXpert), what would it cost to bring them to scale, and how many lives could be saved?

This initial step requires building mathematical models to evaluate the costs and benefits of a combination of interventions to reduce TB mortality. To support the examination of the 'Zero TB Deaths' approach (starting among people living with HIV), modeling work was initiated late January 2011.

Ideally, advocates should be in a position where they can present a Minister of Finance or Health, or donor of influence with a compelling case for increasing support to TB that outlines in clear terms, the relationship between funds invested and outcomes (including lives saved). Modelling can demonstrate that it is possible with today's tools and interventions to save lives much faster than they are being saved at current levels through a 'Zero TB Deaths' approach. This evidence could potentially transform TB advocacy and messaging, increase resource flows, and strengthen political will to end TB deaths. Equipped with this evidence and related messages, current and potential donors and politicians would be able to explain to their constituencies, concretely, how the money spent translates into *lives saved* – a concept easily understood by all. Civil society could be empowered to demand that their governments do more to save lives.

The Tactical Reality: Start with Zero TB Deaths among people living with HIV (PLWHIV). While roughly 400,000 PLWHIV die from TB each year, and there

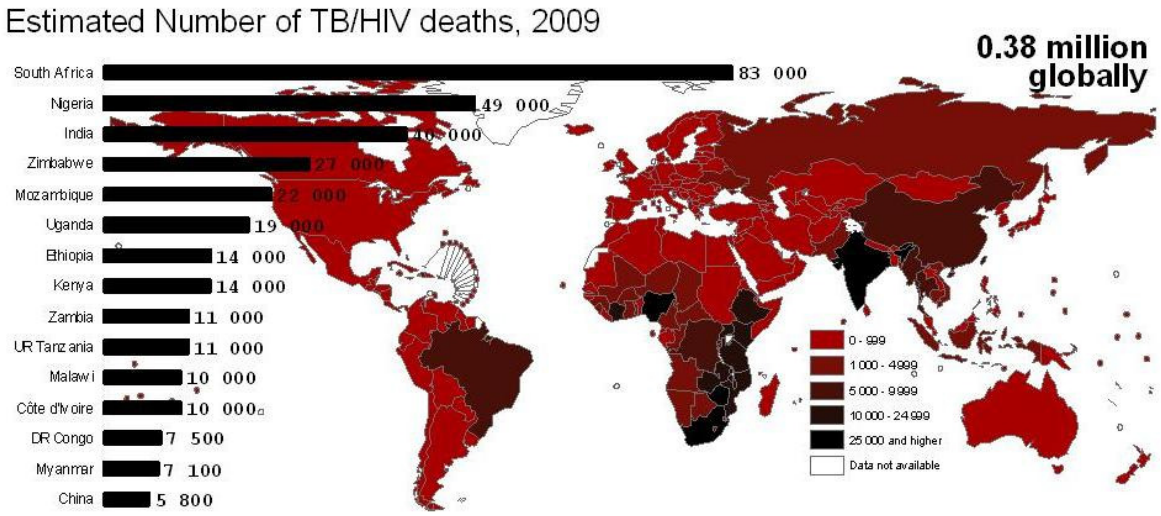
remain 1.3 million HIV-negative TB deaths, there are three reasons to consider focusing initial efforts on PLWHIV as the first step of a "Zero TB Deaths" platform:

1) UNAIDS already has a relatively new public goal of "Zero AIDS-related Deaths" (along with Zero new infections, and Zero discrimination.) "Zero TB Deaths - starting with PLWHIV" is the complementary mirror image of this, is a repackaging of an existing approach, and would demonstrate a unity of vision and purpose from the HIV and TB side.

2) In 2010, a Memorandum of Understanding between UNAIDS and the Stop TB Partnership "To end deaths from TB among PLWHIV" was signed. One of the targets (Objective 1, Target 2) is "Establish country plans to reduce TB deaths by half in people living with HIV in at least ten of the most affected HIV/TB burden countries by end 2011."

3) In June, 2011there will be a high level meeting in New York on AIDS at the UN General Assembly (UNGASS) which will feature a panel on TB/HIV. This could provide an important advocacy platform to announce "Zero TB Deaths - starting with PLWHIV". Preliminary modeling efforts are underway exploring a 'Zero TB Deaths' approach among people living with HIV.

Further efforts to model the impact and cost of Zero Deaths among *all* people with TB will be needed at a subsequent stage to fully assess how many lives could be saved in total.



'Saving Lives' Campaign: A first step towards achieving 'Zero', and catalyzing action towards this objective, is to identify through modeling, the greatest number of lives that could be saved in a defined time frame (e.g.; Campaign to save X million people by Y date, as was the approach used in the 3 X 5 Campaign launched by WHO to set a target of 3 million people on Anti Retroviral Therapy by 2005) and to focus on the 'low-hanging fruit'—those lives that can be saved most cost-effectively.

Looking forward, there are a number of ways such an approach could be harnessed, for example a:

- Campaign to save 1 million lives by 2015 - with a particular focus on PLWHIV dying from TB
- Campaign to save 2 million lives 2016-2020
- Campaign to save 3 million lives 2021-2025
- A donor commitment to halve TB deaths in 10 hotspots (DfID is doing this for malaria for example)

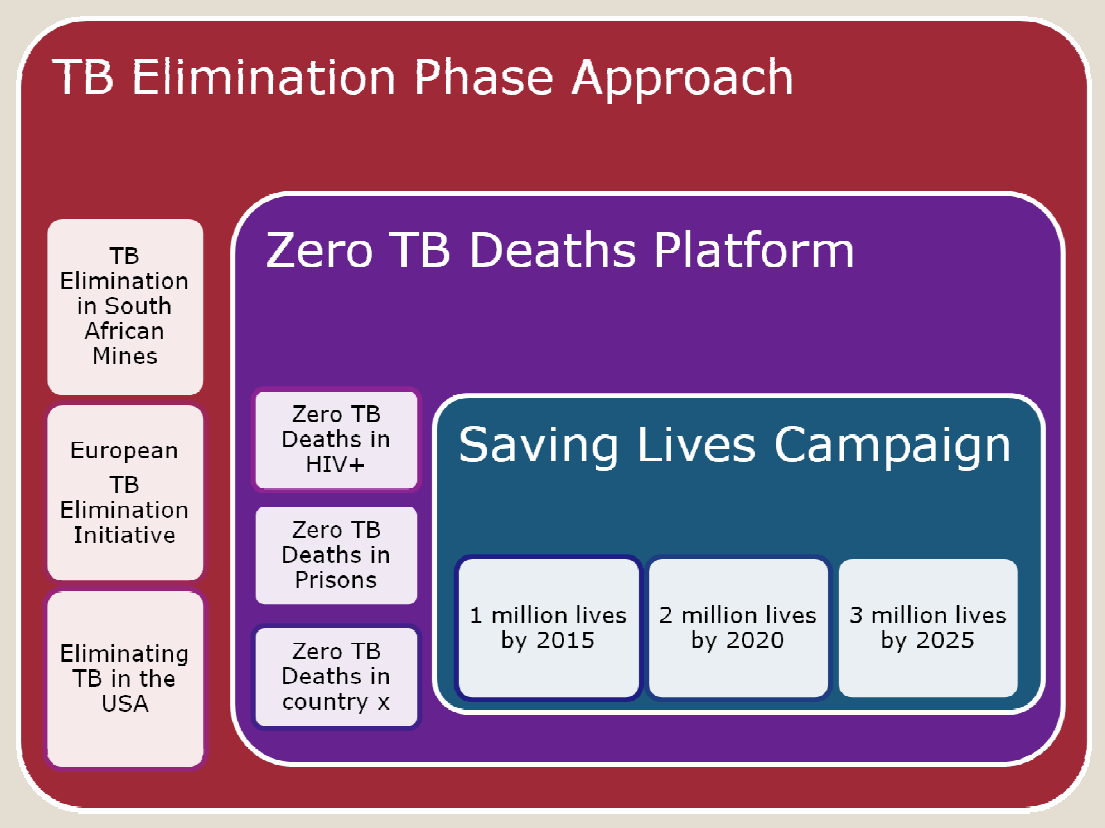
Identifying and encouraging leadership for different geopolitical groupings or sectoral settings such as:

- Brazil's campaign to end TB deaths in Central and South America (BRICS[14] Global Leadership)
- China's Presidential TB Initiative in Africa (BRICS Global Leadership)
- India's state by state campaign to end TB deaths - with states sponsored by high net-worth individuals (HNWIs) or companies (State level)
- Eliminating mine-induced TB in Southern Africa (Sector within a region)
- Eliminating TB in First Nations populations in Canada (defined vulnerable group)

With the exception of the mining initiative, these initiatives do not yet exist. However, they show how approaches can be tailored in different ways: to sub-populations, to state-level, country, region, sector, international effort and more. In most cases they will function on a continuum. The Saving Lives campaign is a first step towards achieving Zero TB Deaths, which is a key component of an Elimination Phase approach.

[14] Brazil, Russia, India, China, and South Africa - a block of emerging market economies increasingly influential in global affairs.

Figure 2: Putting the pieces together: Elimination Phase, Zero TB Deaths and Saving Lives



The white boxes above are illustrative examples although it should be noted that some are underway already. For example:

- There is an initiative under development by the Government of South Africa to eliminate mine-induced TB in 4 Southern African countries, and
- Modeling has been initiated to explore what it would take (and what it would cost) to achieve zero TB deaths among those living with HIV/AIDS.
- TB Elimination in the USA already exists as a platform.

Conclusion:

One of the main issues in this paper is - should this new platform (trying to save as many lives as possible as quickly as possible) be pursued at this particular moment in time? Could this approach transform the conversation the world is having about TB and attract additional resources to help close the more than $4 billion annual shortfall in the Global Plan to Stop TB 2011-2015? If so - what should happen next? This is only one of a number of ideas worth exploring.

The purpose of this discussion paper is to explore how one option - a TB Elimination Phase approach / Zero TB Deaths platform might transform TB advocacy. It is important to note that this is one set of options; there are others worth exploring for

their potential advocacy resonance, for example universal access, cutting mortality and prevalence in half again, etc.

Questions for reflection and further discussion:

- Could such an approach have a positive impact on TB advocacy and messaging and is it worth pursuing?
- How could this approach best help mobilize resources and political will for TB to close the gap in the Global Plan? Could this accelerate funding for R&D such that new tools are developed and rolled out sooner?
- Since in some cases, health systems components would need to be strengthened in lock-step with scaling up certain TB interventions, could this approach also mobilize additional resources for associated health systems components (such as labs, drug management, quality assurance, vital registration systems etc) – and if so, how?
- If worth pursuing, what needs to happen next? e.g.; additional mapping and modeling, further strategy development, communications plan, etc)?

APPENDIX I

Other elimination initiatives currently in progress: lessons to be learnt

Zero malaria deaths by end 2015 - plus phased malaria elimination
Close to a million people, most of them children under five living in Africa, die of malaria each year. In April 2010 a UN Headquarters event on "Bridging the Malaria Gap" brought together members of the African Leaders Malaria Alliance (ALMA) - a coalition of 35 heads of State committed to ending deaths from malaria by 2015. They asserted that it was feasible to provide bednets to everyone living in malaria-endemic countries by the end of 2010 and that this was the most effective means to reach the goal of *zero or near-zero* deaths by 2015.

The latest World Malaria Report released in December offered the following progress:

- Nearly 600 million people in sub-Saharan Africa – about 90 percent of the population — are sleeping under insecticide-treated bed nets.
- Eleven countries in the region have seen malaria cases and deaths plummet by more than half, while Zanzibar has reduced deaths to zero.
- Malaria deaths have also been cut by more than 50 percent in most of the non-African countries where malaria is endemic.

So the 2010 target was missed (but not by a great deal), with little criticism voiced on that count. WHO and others also warned that without stepped up funding, the 2015 target might not be met--a plausible argument in the face of a highly aspirational yet compelling goal.

In parallel, the Malaria Elimination Group has published a guide for malaria elimination (Shrinking the Malaria Map: A Guide on Malaria Elimination for Policy Makers by Richard G.A. Feachem and the Malaria Elimination Group, http://www.malariaeliminationgroup.org/publications. Thirty-nine countries across the world are making progress towards malaria elimination, the authors say. Some are committed to nationwide elimination, while others are pursuing **spatially progressive elimination** within their borders. The guide provides detailed and informed discussion on the practical means of achieving and sustaining zero transmission.

The definitions they are established are worth considering, if the TB community intends to recraft TB epidemiological targets and the way we talk about them. Malaria elimination is defined as the interruption of local mosquito-borne malaria transmission in a **defined geographical area**, **creating a zero incidence of locally contracted cases**. Malaria eradication is defined as the permanent reduction to zero of the worldwide incidence of malaria infection.

Conclusion: the approach taken to the zero deaths/ elimination stage approach by the global malaria community can serve to a considerable degree as a model for TB. Zero has been defined as 'near' zero - and elimination as something countries can achieve in their own time (rather than all at the same time). Having 35 Heads of State call for zero deaths helps.

***Virtual* elimination of mother to child transmission (MTCT) of HIV by 2015**
This objective is backed primarily by advocacy/messaging and a word-of-mouth campaign. The best available literature on the topic is a recent article in the journal *Sexually Transmitted Diseases*. The paper uses modeling techniques to make projections about the feasibility of virtually eliminating MTCT, defined as <5% transmission of HIV from mother to child, or 90% reduction of infections among young children.

The authors drew on data from 25 countries with the largest numbers of HIV-positive pregnant women to evaluate different PMTCT interventions and used a demographic model to estimate new child HIV infections as a measure of the impact of interventions.

Their conclusions: Between 2000 and 2009 there was a 24% reduction in the estimated annual number of new child infections in the 25 countries, of which about one-third occurred in 2009 alone. If these countries implement the new WHO PMTCT recommendations between 2010 and 2015, and provide more effective ARV prophylaxis or treatment to 90% of HIV-positive pregnant women, 1 million new child infections could be averted by 2015.

Reducing HIV incidence in reproductive age women, eliminating the current unmet need for family planning and limiting the duration of breastfeeding to 12 months (with ARV prophylaxis) could avert an additional 264 000 infections, resulting in a total reduction of 79% of annual new child infections between 2009 and 2015, approaching but still missing the goal of virtual elimination of MTCT. To achieve virtual elimination of new child infections PMTCT programmes would need to increase coverage of more effective ARV interventions and safer infant feeding practices.

Conclusion: The objectives of this strategy could be met through a combination of increased political commitment, increased funding and scaled up implementation of existing methods and care. Although not about ending deaths, the definition of elimination i.e. xxxx is much more achievable than the TB definition of <1/1million. The definition is key to success. It provides a good advocacy model for a zero or virtually zero TB deaths strategy.

Source: "What will it take to achieve virtual elimination of mother-to-child transmission of HIV? An assessment of current progress and future needs
Mary Mahy, John Stover,Karusa Kiragu,Chika Hayashi,Priscilla Akwara, Chewe Luo, Karen Stanecki, Rene Ekpini, and Nathan Shaffer
doi: 10.1136/sti.2010.045989 2010 86: ii48-ii55 *Sex Transm Infect*

Global Polio Eradication Initiative

The global effort to eradicate polio was launched in 1988 and led by the World Health Organization, UNICEF and The Rotary Foundation. It would seem a realizable goal, since there is a highly effective vaccine available that can be administered by mouth. The most important step in eradication of polio is interruption of endemic transmission of poliovirus through mass vaccination and surveillance of possible

outbreaks. Since the launch of the initiative the number of annual diagnosed cases has plummeted from the hundreds of thousands to less than a thousand.

But in 2008, alarmed that polio remained entrenched in the four countries that had never stopped transmission and that an increasing number of polio-free areas were becoming re-infected, in May 2008 the World Health Assembly called for a new strategy to complete polio eradication.

Subsequently WHO launched a strategic plan for 2010–2012, which sets out an aggressive, time-bound programme of work aimed at interrupting wild poliovirus worldwide by 2013. The plan sets forth clear, time-bound targets: :

- By mid-2010: Cessation of all polio outbreaks with onset in 2009
- By end-2010: Cessation of all 're-established' poliovirus transmission
- By end-2011: Cessation of all polio transmission in at least two of the four endemic countries
- By end-2012: Cessation of all wild poliovirus transmission.

The Plan asserts that with full financing and implementation interruption of the remaining reservoirs of wild polio virus worldwide by 2013 is feasible.

Conclusion: It is a stretch to compare polio eradication to TB elimination, since the former has as its foundation a broad immunization campaign. But there are lessons to be learnt. Despite serious obstacles to global polio eradication in the form of limited basic health infrastructure in the African and Asian countries that still have cases every year and the crippling effects of civil war and internal strife, polio continues to maintain high levels of funding and momentum around the possibility of ridding the world of another disease - and saving future costs by investing now. Although there are only around 2,000 cases today, annual investments are still around $1 billion. This is an astronomical cost per case and yet the possibility of eradication, the broad based campaigns (i.e. Rotary), and a champion like Bill Gates are key success factors.

Source: Global Polio Eradication Initiative Strategic Plan 2001-2012, http://www.polioeradication.org/ResourceLibrary/Strategyandwork/StrategicPlan.asp

Annex VI: 2011 Timeline

Month	Event	Location
March	TB Research Movement high-level meeting	Bellagio, Italy
	World TB Day	Worldwide
	WHO MDR-TB report launch	Washington, DC
	African Union Minister of Finance and Minister of Health Meeting	Ethiopia
April	Clinton Global Initiative annual meeting	San Diego, CA
	Stop TB Partnership high-level mission	Washington, DC
	Stop TB Partnership Coordinating Board meeting	Washington, DC
	Global Business Coalition: "CSR & Health in China"	Beijing/Shanghai
	Global Health Innovate Conference	Yale, US
May	64th World Health Assembly	Geneva
	2nd wave of TB REACH funding announced	Geneva
June	UNGASS/HIV Thematic Panel on TB/HIV	New York
	2011 Pacific Health Summit (vaccination)	New York
	4th Global Fund Partnership Forum	New York
	Global Health Council 2011 Conference	New York
	Regional ministerial forum: "Eliminating TB in Miners in 4 SADC Countries"	Seattle
	37th G8 Summit	São Paulo
	WHO Strategic and Technical Advisory Group meeting	Washington, DC
	Mobile Health Summit, GSMA and mHealth alliance	Johannesburg, South Africa
		Deauville, France
		Geneva
		Cape Town, South Africa
July	6th International Aids Society Conference on HIV	Rome
	Conference of the Union Asia-Pacific Region	Hong Kong
August	International Congress on AIDS in Asia Pacific	Busan, Korea
September	Non-communicable Disease Summit, United Nations General Assembly	New York
	Clinton Global Initiative Annual Meeting	New York
October	42nd Union World Conference on Lung Health	Lille, France
	World Health Summit	Berlin
	Eastern Europe and Central Asia MDG6 Forum	Moscow
November	Business for Social Responsibility Conference	San Francisco
	G20 Summit	Cannes
	Fourth High Level Forum: the Path to Effective Development	Busan, Korea
December	EED European Development Days	Brussels
	mHealth Summit	Washington

Annex VII: Advocacy feedback from working group subgroups

Dots Expansion Working Group:

Advocacy, Communication and Social Mobilization (ACSM) subgroup:

a) 2011 advocacy activities: The ACSM Subgroup's main advocacy goal for 2011 is to advocate for increased commitment and resource allocation for country-level ACSM. There is a need for implementers (NTPs, NGOs, etc.) to see ACSM as a set of strategic activities that, as part of the Stop TB Strategy, are critical in addressing specific TB, TB/HIV and MDR-TB control challenges. This advocacy push needs to be supported with evidence of effective ACSM in TB control.

b) Main targets of advocacy: NTPs (focus on HBCs), Country's authorities and major implementing NGOs. GFATM, other donors, technical partners

c) Key advocacy challenges: There is a lack of ACSM representation in country missions and meetings where such advocacy could take place (for example country joint review missions or key international TB meetings).

d) Upcoming advocacy opportunities: Country missions to Viet Nam, Thailand, Peru, China, Uganda and Cambodia, regional NTP managers meetings, Union Conference sessions (Symposium, Workshop).

Human Resources Development subgroup:

a) 2011 Description of WG's advocacy activities: Participation in other workgroup meetings to ensure inclusion of HRD best practices and participation in global and regional meetings to ensure inclusion of HRD best practices.

b) Main targets of advocacy: Donors and partners

c) Key advocacy challenges: Expand knowledge of HRD best practices to partners and donors, i.e., beyond the concept of training existing health care workers.

d) Upcoming advocacy opportunities: European Collaborative meeting; Global IUATLD meeting

Public-Private Mix subgroup:

a) 2011 advocacy activities:

- Promotion and dissemination of the PPM toolkit and related video
- Dissemination of e-updates on the work of the subgroup
- Promotion of PPM in various conferences such as the Union Conference
- Updating the PPM Subgroup and WHO PPM websites

b) Main targets of advocacy: National TB programmes, non-NTP care providers, Regional Offices, Partners, Donors.

c) Key advocacy challenges: Documenting results and analysing impact, influencing national programmes and providers to work with each other, funding.

d) Upcoming advocacy opportunities: Union Conference in Lille, World TB Day, FIP Conference in India.

TB and Poverty subgroup:

a) 2011 advocacy activities: A systematic review of interventions for addressing socioeconomic-related conditions as part of TB treatment:

- The systematic review and a draft report were finalized.
- Plans for publishing and dissemination are being developed, including a possible WHO policy brief.
- The review of impact data has been accepted for publication in IJTLD, in a theme issue on ethics and social determinants of TB.
- The review of the implementation challenges is under consideration for a second publication.
- Findings were presented at The Union conference in Berlin in the Symposium on social determinants
- The review will serve as a basis for an expert meeting on socioeconomic interventions for improved TB control, planned for 2011
- Several members of the core group contributed to the development of a theme issue for IJTLD on ethics and social determinants of TB. The issue will be published in 2011.

a) Main targets of advocacy: Addressing and promoting concepts related to poverty in tuberculosis control programs, increasing stakeholder involvement and providing recommendations to programmes designed to improve access to TB services for the poor.

b) Key advocacy challenges: Budget constraints, bringing stakeholders together on a common platform, putting poverty on countries' health agendas.

d) Upcoming advocacy opportunities: Engaging of practitioners, NGOs and other stakeholders, including representatives of poor women and men, tribal or indigenous populations to promote the access of the poor to TB services: At the time of reporting and over the period Aug-Dec 2010, the secretariat is examining poverty-centric approaches within the scope of a Global Fund Round 9 Tuberculosis grant in India that is being implemented across 21 states in a project target population of 600 million in India (including 174 million women and 199 million children). The objective is to explore poverty action and research possibilities within the scope of project that specifically targets ACSM interventions in 250 million people living in poor and backward districts (includes 50 million tribal/indigenous populations, and 40 million people in urban slums). The civil society interventions in the project implemented by the principal recipient – Union south-east Asia office provides a unique opportunity to the secretariat to examine synergies, engage NGO and public sector stakeholders to promote access of the poor to TB services at country level. The secretariat perceives this project offers potential engagement opportunities for the core team members to develop tools and guidelines for poverty.

TB-Infection Control (TB-IC) subgroup

a) 2011 advocacy activities
In 2010, an advocacy strategy for adoption and dissemination of the WHO policy on TB infection control in health-care facilities, congregate settings and households, has been published and disseminated.

In 2011, as mentioned above, a proposal has been send to TB CARE in order to support the development of a Core Package of IC interventions. The objective of this project is to develop, through consensus, a core TB-ICl package that is likely to be effective, marketable, implementable and measureable in various regions of the world. This core TB-IC package should be then part of future campaigns.

b) Main targets of advocacy: They will be discussed during the consensus meeting for the deliverable described above.

c) Key advocacy challenges: To be determined in the upcoming consensus meeting.

Subgroup on Culture-based diagnostics and resistance. Subgroup is maintained (see Overview) and will be named Drug Susceptibility Testing

a) 2011 advocacy activities: Use of microscopic-observation drug-susceptibility (MODS), nitrate reductase assay (NRA) Colorimetric Redox Indicators (CRI).

b) Main targets of advocacy: National Reference labs, National TB programmes, donors, technical assistance partners

c) Key advocacy challenges: There is little echo by the WHO and the Partnership on the "WHO-endorsement" of these methods, which offer important potential to rapidly increase case detection and detection of DRTB. Attention is placed almost exclusively on new molecular test (Xpert TB), which despite being a great instrument, is not all that is needed.

d) Upcoming advocacy opportunities: The Union meetings, NDWG website

Subgroup on Evidence Synthesis for TB diagnostics. Subgroup is maintained as cross-cutting theme and will be named Evidence Synthesis and Policy

a) 2011 advocacy activities: Plain language summaries – this is a project that lends itself to participation by the wider community. Effective and evidence-based information is the groundwork for advocacy.

b) Main targets of advocacy: TB patients and community activists, also health care providers, scientists, policy makers, and funders

c) Key advocacy challenges: A well thought out strategy. Time and money. The plain language summaries could be translated in to languages other than English.

d) Upcoming advocacy opportunities: Union World Conference on Lung Health, 2011 –opportunity to get feedback on plain language summaries.

Childhood TB subgroup

(xii) Advocacy activities:
a) Advocacy activities for 2011: The sub-group is of a technical nature, therefore, it does not conduct 'pure' advocacy activities per se. However, the subgroup tries to communicate the message of what needs to be done in childhood TB to high level audiences, such as donors, politicians, ministries of health in high burden countries and national TB programmes.

b) Main targets of advocacy: Donors, ministries of health in high burden countries, national TB programmes

c) Key advocacy challenges: Childhood TB is low priority for national TB programmes, because it is perceived to be difficult to diagnose (only a small proportion of children with TB would be smear positive). It is usually non-infectious and most patients would not be referred to NTPs, but to hospitals or the private sector.

d) Upcoming advocacy opportunities: A childhood TB conference organized jointly by the sup-group and the European Centre for Disease Prevention and Control (ECDC) with the main objectives to:

1. Identify and highlight the gaps, challenges and needs in childhood TB control
2. Prepare the scientific rationale behind the need for advocacy and to identify the key areas where more advocacy and targeted engagement with stakeholders is needed
3. Reach a consensus on how to advocate for childhood TB control in light of the MDG 4 for child survival and how to bring forward the voice of children.