ANNUAL REPORT
2012

Stop TB Partnership

ABOUT THE STOP TB PARTNERSHIP

The Stop TB Partnership is leading the way to a world without tuberculosis (TB), a disease that is curable but still kills three people every minute. Founded in 2001, the Partnership's mission is to serve every person who is vulnerable to TB and ensure that high-quality treatment is available to all who need it.

Together our more than 1000 partners are a collective force that is transforming the fight against TB in more than 100 countries. They include international and technical organizations, government programmes, research and funding agencies, foundations, NGOs, civil society and community groups and the private sector.

We operate through a Secretariat hosted by the World Health Organization (WHO) in Geneva, Switzerland and seven working groups whose role is to accelerate progress on access to TB diagnosis and treatment; research and development for new TB diagnostics, drugs and vaccines; and tackling drug resistant- and HIV-associated TB. The secretariat is governed by a coordinating board that sets strategic direction for the global fight against TB.

Our vision is a world free from TB

INTRODUCTION

2012 was a landmark year for the Stop TB Partnership. The Secretariat continued to work with partners in three main areas while carrying out an extensive review of its operating priorities.

These areas, reported on in this report, are:

1. Review of operating priorities - New Operational Strategy

2. Raising the profile of TB among decision makers to mobilize resources and increase political commitment

3. Strengthening engagement of existing and new partners

4. Getting high-quality TB services, drug and treatment care to more people, especially poor, marginalized and vulnerable groups

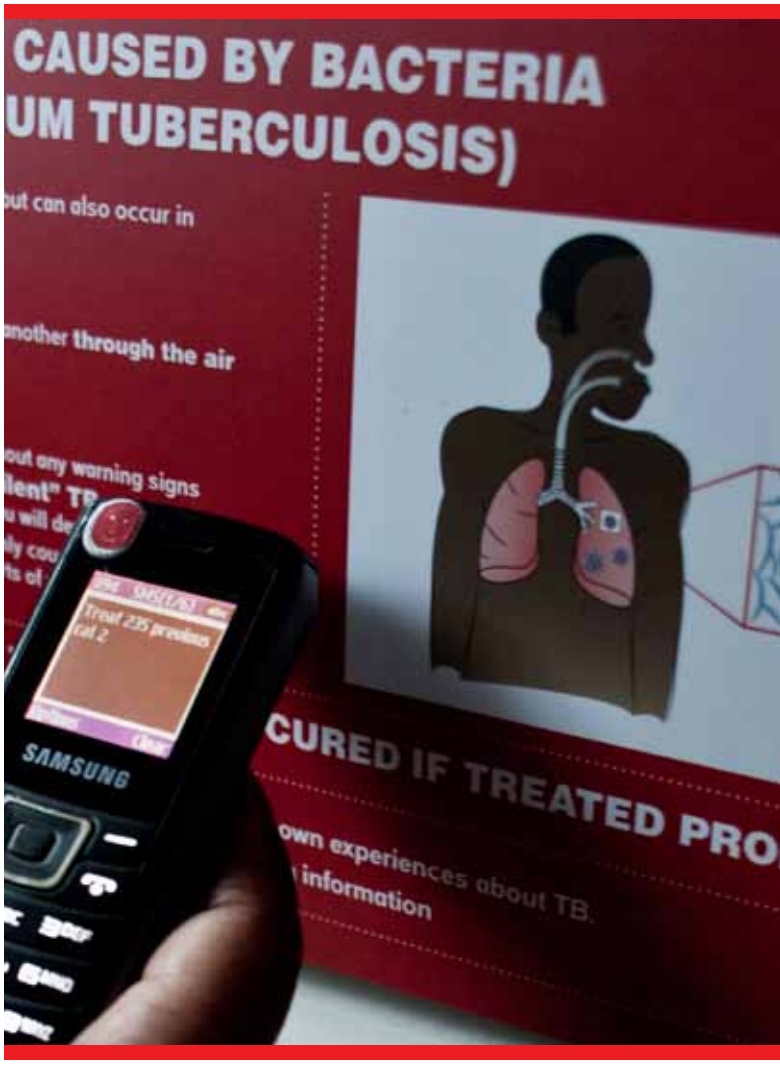
1. REVIEW OF OPERATING PRIORITIES NEW OPERATIONAL STRATEGY

In January 2012, the Stop TB Partnership Coordinating Board requested the development of a three-year Operational Strategy, to be implemented from 1 January, 2013 through 31 December 2015. The strategy, approved in November 2012, serves as a roadmap for how the Partnership Secretariat, based on its comparative advantages and available financial and human resources, serves the Partnership and contributes to the Global Plan to Stop TB.

The Operational Strategy outlines the Partnership Secretariat's four strategic priorities over three years. Given the significant resource constraints facing the Secretariat, this strategy represents a significant prioritization and streamlining of the activities and initiatives undertaken through 2012. These priorities have been developed based on the Secretariat's comparative advantages and available financial resources.

The role of the Partnership Secretariat is facilitating, catalyzing, and coordinating partners, which it is uniquely positioned to do. The Secretariat is focusing on strengthening support to all current and future partners, working groups and other partnership bodies. The Secretariat will identify shared opportunities, the most effective ways to sustain and expand their engagement and create platforms for their interaction and collaboration.

The Partnership Secretariat has a strong comparative advantage in global advocacy efforts as a neutral voice in TB advocacy and resource mobilization, with the ability to amplify the voices of partners. The Secretariat facilitates and links partners with common areas of interest and creates a platform to facilitate consensus and coordinate advocacy approaches. The Secretariat will continue its flagship initiatives, GDF and TB REACH, which provide critical services through and for our partners.



The four strategic goals of the **New Operational Strategy** are as follows:

1. Facilitate
meaningful and sustained collaboration among partners

2. Increase
political engagement by world leaders and key influencers to double external financing for TB from 2011 to 2015

3. Promote
innovation in TB diagnosis and care through TB REACH and other innovative mechanisms and platforms

4. Ensure
universal access to quality assured TB medicines and diagnostics in countries served by the Global Drug Facility (GDF)

2. RAISING THE PROFILE OF TB AMONG DECISION MAKERS TO MOBILIZE RESOURCES AND INCREASE POLITICAL COMMITMENT

2012 saw important breakthroughs in TB advocacy. Regional political fora, first and foremost the Southern African Development Community (SADC) and BRICS countries, showed strong leadership and initiative on TB, providing impetus to global discussions and resource mobilization activities for TB.

2.1 TB AND MINING

On 18 August the fifteen SADC Heads of State signed a Declaration on TB in the Mining Sector, committing them to address the raging TB epidemic among current and ex-mine workers, their families and affected communities.

The SADC Declaration represents the first heads of state declaration on TB in Africa and a real opportunity to tackle the source of the epidemic in the region. Miners, who are often migrant workers from Swaziland, Lesotho or Mozambique, have the highest TB rates in the world and are likely to infect on average another 10 – 15 persons with TB. Tackling TB in the mining sector, therefore, represents a real chance of turning the epidemic in Southern African countries.

Three members of the Stop TB Partnership Coordinating Board have been the driving force behind the initiative that led to the Declaration: Dr Aaron Motsoaledi, Minister of Health of South Africa; Dr Mphu Ramatlapeng, Vice-Chair of the Global Fund Board and former Minister of Health of Lesotho; and Mr Benedict Xaba, Minister of Health of Swaziland.

The three raised the issue of TB and mining to the SADC agenda in November 2011. This was followed in March 2012 by a SADC stakeholders meeting in Johannesburg - supported by the International Organization for Migration (IOM), the Stop TB Partnership, the World Bank and other partner organizations - at which representatives from governments, trade unions, the private sector, nongovernmental organizations and donors provided their inputs. The declaration was subsequently endorsed by SADC ministers of health, labour and justice, paving the way for signatures by the Heads of State.

The Stop TB Partnership has played a coordinating role, fostering multi-lateral collaborations with the World Bank and International Organization for Migration in order to ensure the implementation of the Declaration.

2.2 BRICS LEADERSHIP

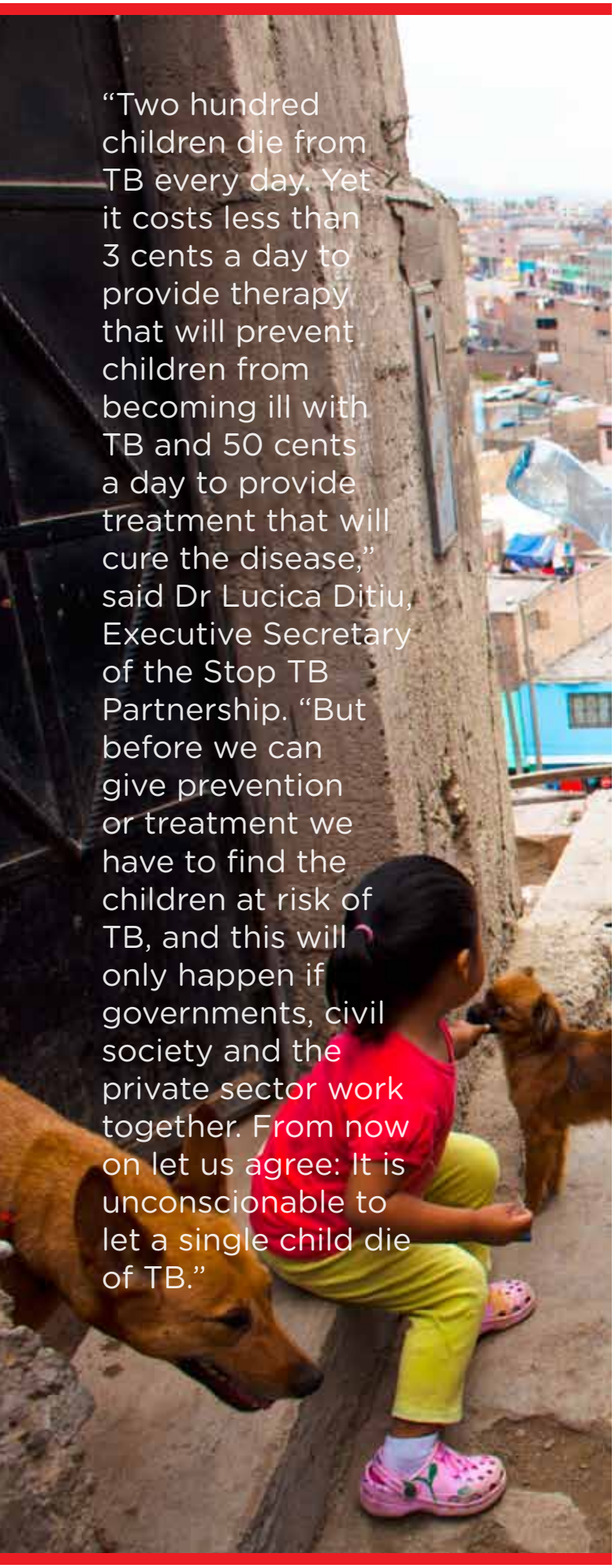
In 2012, BRICS health ministers developed a pact to enhance their cooperation on drug-resistant TB, to be formalized in a pact in 2013. The majority of global drug-resistant cases, around 60%, occur in Brazil, China, India, the Russian Federation and South Africa alone. A BRICS initiative on drug-resistant TB therefore not only has the chance to tackle a large scale of the problem, but these countries also have the power to raise the profile of TB at a global stage and to transform this issue from a low-attention subject to a global agenda item. All five BRICS countries are represented at ministerial level at the Stop TB Partnership Coordinating Board and exchange of views take place on a regular basis. The Partnership Secretariat will continue to work with its ministerial champions from the BRICS countries in order to support their cooperation on drug-resistant TB.

2.3 KICK-STARTING A GLOBAL RESPONSE TO CHILDHOOD TB

In 2012, The Stop TB Partnership Kochon Prize 2012 was awarded to the Desmond Tutu TB Centre at Stellenbosch University in South Africa. The announcement was made during the World Conference on Lung Health, held in Kuala Lumpur, Malaysia, in November.

For the first time, the 2012 prize focused on the specific theme of Childhood TB. The Desmond Tutu TB Centre was honoured for its ground-breaking research on childhood TB and for pioneering community-based approaches to TB and HIV care.

Desmond Tutu responded to the award in a video message, calling for greater action against the neglected epidemic of childhood TB.



TB often goes undiagnosed in children from birth to 15 years old because they lack access to health services - or because the health workers who care for them are unprepared to recognize the signs and symptoms of TB in this age group.

On World TB Day 2012, the World Health Organization (WHO) and Stop TB Partnership made a global call to address this hidden epidemic. In an advocacy brochure No more crying, no more dying, the organizations said that, with better training and harmonization of the different programmes that provide health services for children, serious illness and death from TB could be prevented in thousands of children every year.

Recent studies have shown, however, that when health programmes do start looking for children with TB, they find far more cases than expected. In Karachi, Pakistan, in 2011, researchers trained community members in the Korangi and Bin Qasim Towns to use an electronic score card on a mobile phone to find people who needed a TB test and then accompany them to the hospital or clinic. One result was a 600% increase in detection of pulmonary TB among children. Another recent study in Bangladesh found that the number of children found to have TB more than trebled when workers at 18 community health centers received special training on childhood TB.

To kick-start a global movement against childhood TB, WHO and the Stop TB Partnership pointed to three key actions needed to improve TB care and prevent TB deaths in children:

- Examine all children who have been exposed to TB through someone living in their household. If they are very ill or living with HIV, treat them for TB immediately if they have typical signs and symptoms - even if a definitive diagnosis unavailable.

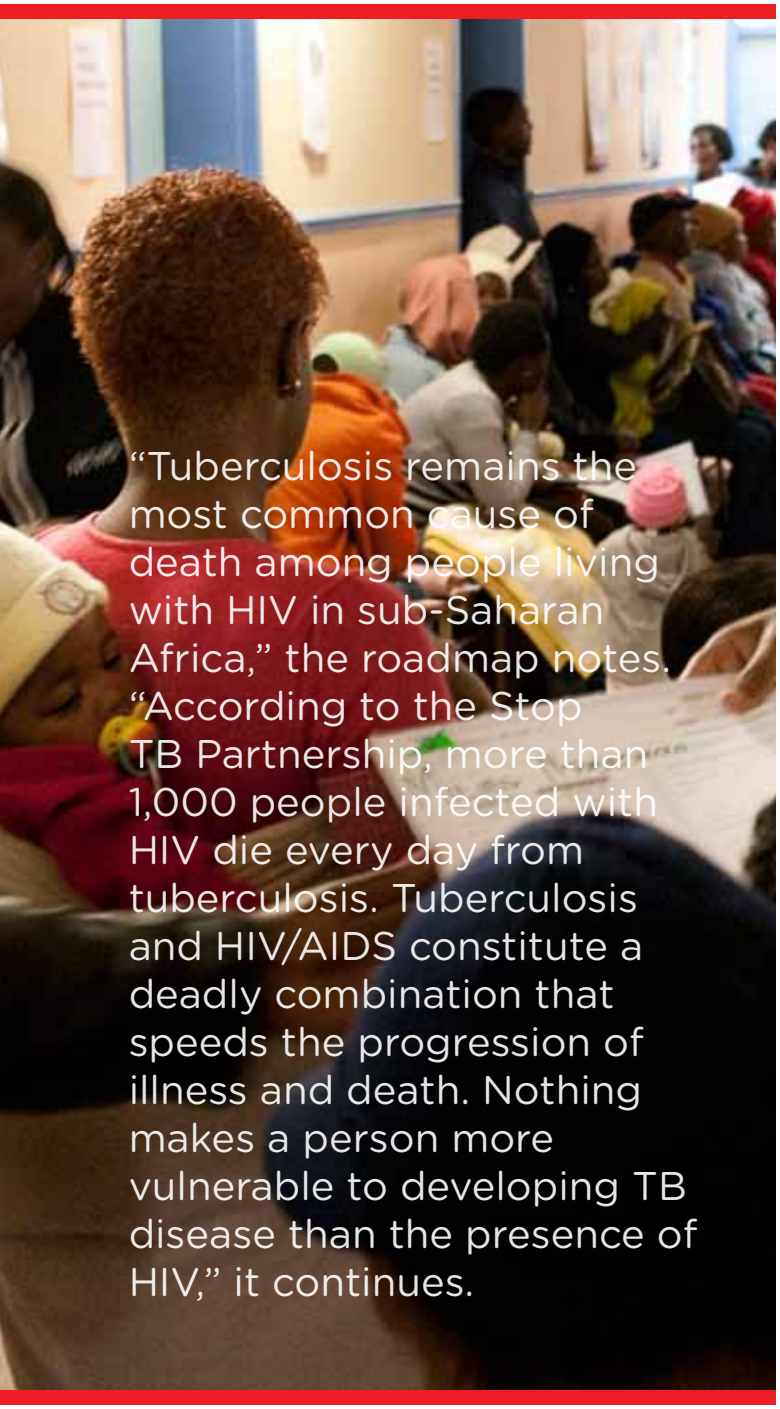
- Provide preventive treatment with the drug isoniazid to all children who are at risk for TB but are not ill with the disease.

- Train all health workers who care for pregnant women, babies and children to check patients for TB risk, signs and symptoms and refer them for TB preventive therapy or TB treatment as needed.

2.4 TB/HIV GOES MAINSTREAM

In 2012, the US Secretary of State Hillary Clinton unveiled the PEPFAR Blueprint, providing a roadmap for how the US Government will work to help achieve an AIDS-free generation.

The roadmap identifies "smart investments" that PEPFAR will prioritize based on evidence indicating they will save the most lives, and specifies six action steps. Prominent among these is an action step to: Target HIV-associated tuberculosis and reduce co-morbidity and mortality.



The roadmap goes on to specify the steps needed to end HIV-associated TB among people living with HIV: a combination of widespread ART coverage, early identification and treatment of TB, isoniazid preventive therapy (IPT), and infection control activities.

The inclusion in the PEPFAR blueprint follows several years of advocacy on the part of Stop TB Partners and the Working Group on TB/HIV to integrate TB into HIV strategies and implementation.

2.5 CIVIL SOCIETY RAISES THE VOLUME AT THE WORLD CONFERENCE ON LUNG HEALTH

The TB community has the reputation of being highly technical, precise and subdued. But this was not the case at the 2012 World Lung Conference on Lung Health, held in Kuala Lumpur, Malaysia. Ahead of the opening session, some 100 TB activists marched through the Convention Centre, just as delegates were taking their seats. They were an outspoken crowd, demanding more ambitious targets for stopping TB, the funding to meet those targets and an end to the use of detrimental language in the TB community.

"The Union conference is the one place where everyone in the TB world comes together. If it were to pass without any significant activist visibility, our calls for action would remain just words. This year we wanted to make our presence felt in a much stronger way," said Blessina Kumar, Vice-Chair of the Stop TB Partnership Coordinating Board and a representative for communities affected by TB. "The urgency to address TB is somehow absent. We need that urgency as people are dying every minute. We as activists are willing to do anything to ensure that this urgency is there at the forefront of the minds of governments, funders and those who are setting global targets for TB."

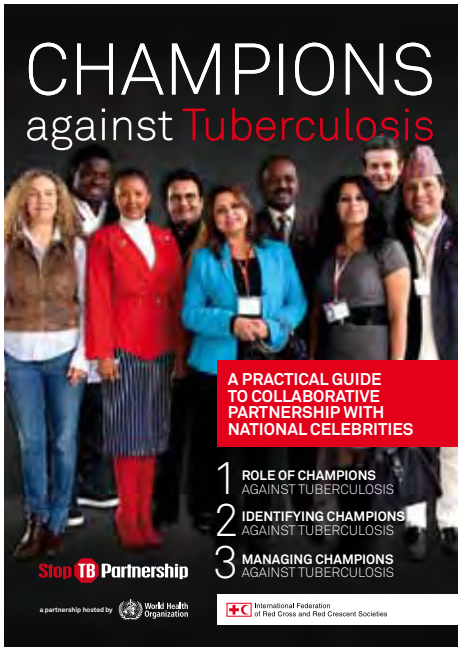
Some of the protesters carried placards calling for "zero TB deaths", "more funding for TB", or "nothing for us without us". Others placards were blazoned with the messages "50% won't cut it" and "no blood on our hands" (both referring to the proposed target of reducing TB deaths by 50% in the post-2015 era - which would still leave 600, 000 people dying per year).

2.6 UN SPECIAL ENVOY HONOURED BY GLOBAL HEALTH AND DIPLOMACY

In September, Global Health and Diplomacy, a centre that convenes leaders in health and foreign affairs to discuss challenges and find solutions to global health matters, honoured its 2012 champions. These included Dr Jorge Sampaio, former President of Portugal and the UN Secretary-General's Special Envoy to Stop TB (centre, front); His Excellency Yayi Boni, President of Benin, (fourth from right, second row) and Michel Sidibe, Executive Director of UNAIDS. On this occasion the three global health leaders joined Global Health and Diplomacy in ringing the closing bell at NASAQ QMX, the world's largest exchange company.

2.7 A PRACTICAL GUIDE TO WORKING WITH NATIONAL CHAMPIONS

In November, the Stop TB Partnership launched a guide to working with national celebrities. The handbook, A practical guide to collaborative partnerships with celebrities, co-produced with the International Federation of Red Cross and Red Crescent Societies, provides Stop TB Partners with guidance on how to engage celebrities and benefit from their support. The targeted audience is mainly public health professionals who would like to expand their knowledge for engaging celebrities and managing high profile events. The objective is to share the experience gained while working with current champions against TB.



Speakers at the launch event in Kuala Lumpur included Awad Ibrahim Awad, A TV presenter who serves as Sudan's national TB champion; Ms Rania Ismail, performer and Jordan's national TB champion; Lucy Achieng, of Nagoke Youth, Uganda; Mr Alberto Colorado, aTB Activist from the United States; Mr Hou Fengzhong, of the Chinese Red Cross; and Dr Karam Shah, a medical officer in the World Health Organization Afghanistan country office.

3. PROMOTE INNOVATION IN TB DIAGNOSIS AND CARE THROUGH TB REACH AND OTHER INNOVATIVE MECHANISMS AND PLATFORMS

3.1 THE PARTNERS' DIRECTORY: AN INFORMATION HUB FOR THE TB COMMUNITY

In 2012, the Stop TB Partnership Secretariat carried out a biannual update of its directory of partners. When the project was completed in December there were a total of 953 active partners with a complete profile in the directory.

3.2 SHARING GOOD PRACTICE ON NATIONAL PARTNERSHIPS

In 2012, the Secretariat continued to work with partners to help them develop national partnerships. These voluntary alliances draw on the skills and competencies of partners to increase efficiency, avoid duplication of effort and extend the reach of TB services.

The Secretariat's work focused on gathering good practice information to encourage the development of further national partnerships and help build capacity in countries. Fifty-eight representatives from national partnerships provided expert advice and information based on their experiences which was compiled in a draft publication for discussion at the World Conference on Lung Health in Kuala Lumpur in November. The final publication will be published in 2013.

3.3 THE REGIONAL FORUM OF NATIONAL PARTNERSHIPS TO STOP TB

In November, the Korea Stop TB Partnership and the Stop TB Partnership co-hosted the

first ever Regional Forum of National Partnerships to Stop TB in the WHO Western Pacific and South-East Asia Regions in Seoul, Republic of Korea. Representatives from NGOs, national TB programmes, communities and the private sector met to share best practices, discuss common challenges and develop country-specific and regional plans of action to strengthen efforts to stop TB.

The meeting led to the adoption of a work plan and set of prioritized activities for the national partnerships of India, Indonesia, Japan, Nepal, Philippines, Thailand and Vietnam.

The event was attended by government officials, members of congress, donors and other high-level representatives, increasing the regional profile of TB and the role of partnerships in combatting it.

3.4 COUNTRY SUPPORT: THAILAND

In January, the Stop TB Partnership Secretariat brought together representatives from Thailand's national TB programme and NGOs to discuss challenges in delivering TB care in the country.

They resolved to address a critical issue: the provision of healthcare to migrants from neighboring countries who do not have access to the country's health insurance schemes.

The NGOs, supported by the Global Fund, started to fill the gap in TB diagnosis and treatment provision, winning the support of community leaders from the migrant populations. External financing is now due to end but the national TB programme and NGOs plan to continue their collaboration through the national partnership.

3.5 COUNTRY SUPPORT: NIGERIA

At the request of the national TB programme manager, the Stop TB Partnership Secretariat visited Nigeria in April to assist the national partnership in the development of a joint action plan to support the national strategic plan for TB control. The Secretariat helped the national partnership carry out a mapping exercise to identify the core competences, resources and reach of each partner. Following this exercise, partners volunteered to contribute to the joint plan in three general areas. The Ministry of Health and national TB programme volunteered to provide policies and guidelines for TB prevention and care; civil society volunteered to contribute to mobilizing communities; and the private sector committed to collaborate based on their expertise on issues such as advocacy and communications strategies. The mapping led to several collaborations between partners. For example, one NGO that had a microscope but no formal training in how to use it was able to access medical training from another partner, allowing diagnostic services to be provided in areas where they were lacking.

4. GETTING HIGH-QUALITY TB SERVICES, DRUG AND TREATMENT CARE TO MORE PEOPLE, ESPECIALLY POOR, MARGINALIZED AND VULNERABLE GROUPS

4.1 TB REACH

More than nine million people around the world become ill with tuberculosis (TB) each year. The disease is curable, but efforts to find and treat people with TB have stagnated. In 2011, a third of the people who got sick with TB went without an accurate diagnosis or effective treatment, stacking the odds against their survival and encouraging drug-resistance. This proportion has remained stubbornly high for the past six years.

TB REACH offers a lifeline to these people by funding innovative projects that find and treat people with TB in some of the poorest, most vulnerable communities in the world. In areas with limited TB care, TB REACH acts as a pathfinder, providing fast track funding for innovative projects, monitoring their effectiveness and leveraging domestic and international funding for scale up.

TB REACH was launched in 2010 with a CAD $120 million grant from the Canadian Government. It's performance is measured by an independent monitoring and evaluation agency.

In 2012, TB REACH grantees continued to use new approaches to find and treat people with TB.

TB REACH partners worked on 44 different projects in 29 countries, covering a population of 202 million people. They diagnosed 124 724 people with TB, 16% more than what was expected according to trends. Some projects delivered even more dramatic results, doubling case detection rates.

Evaluation of the first wave of TB REACH projects showed that overall case detection increased by 33% and in some projects even doubled within a year.

In its first two years of operation, TB REACH has demonstrated that there is an alternative to the global stagnation in case detection rates. Partners have shown that local solutions can greatly improve outcomes for patients and must now be scaled up. TB REACH is working to promote and integrate these lessons learned at a larger scale.

In 2012, the TB REACH Secretariat, together with the WHO Stop TB Department, made a successful proposal to UNITAID for the scale up of the Xpert MTB/RIF rapid diagnostic test in 21 countries. The Executive Board of UNITAID approved funding of US$ 30 million to scale up access to Xpert MTB/RIF, and reduce the cost of its use.

Under the grant, TB REACH supports partners in deploying Xpert machines and cartridges supplied by UNITAID. The grant triggered a reduction in the price of Xpert test cartridges from US $17 to less than US$ 10. The partnership with UNITAID will bring a Xpert machines and tests worth a total of US $4.5 million to people in need.

The UNITAID partnership also supported TB REACH grantees in Pakistan, Bangladesh and Indonesia in developing sustainable business models for the delivery of Xpert testing in the private sector.

Funding from TB REACH and UNITAID will provide nearly 500, 000 Xpert tests and 75 machines to these three countries with the expectation that these projects will be self-sustaining after donor support has ended.

TB REACH launched its third wave of funding in 2012, drawing 324 applications of which only 35 could be funded. This high demand, coupled with TB REACH's strong results, suggest that similar fast-track, high-performance programme models could be used to improve progress on other areas of TB where performance is lagging.

4.2 GLOBAL DRUG FACILITY (GDF)

The Global Drug Facility (GDF) is more than a procurement mechanism: it provides a unique package of services, including the procurement of high-quality tuberculosis (TB) drugs and diagnostics at affordable and sustainable cost, technical assistance to countries on drug management and monitoring of drug use. It actively shapes the market for TB drugs, linking drug demand with supply and monitoring activities, outsourcing services to partners on a competitive basis and using innovative product packaging to simplify drug management. GDF began supplying first-line drugs (FLDs) in 2001, and in 2008 added the supply of second-line drugs (SLDs), paediatric TB medicines and diagnostics. It is now a major source for the GeneXpert diagnostic.

In 2012, GDF continued to deliver its mandate to supply quality-assured anti-TB drugs for first and second line TB treatment as well as laboratory equipment to meet countries' needs, either in the form of grants or a the lowest price possible.

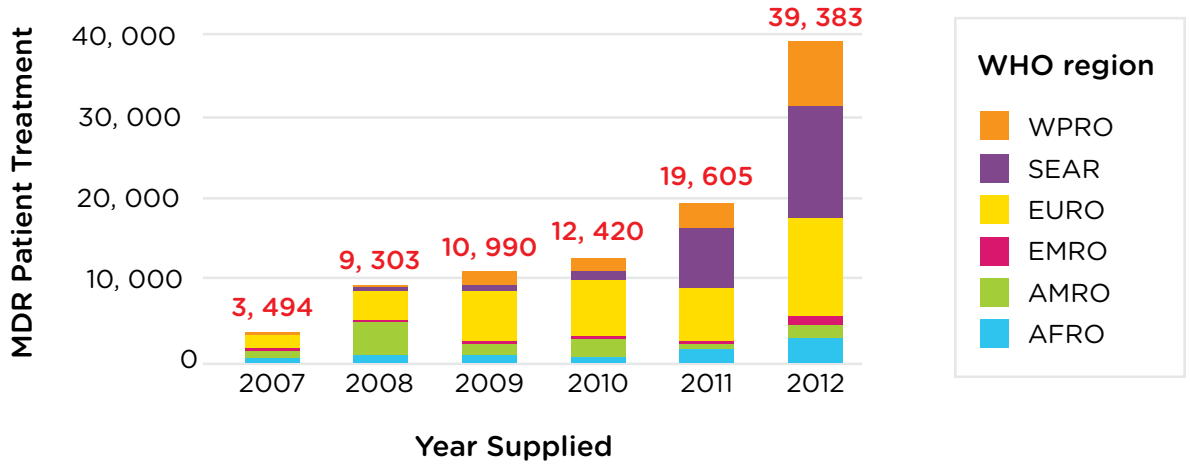
The total volume of goods procured totaled US $ 151 million in 2012, including US $58 million in first line drug treatments , US $74.5 million in second line drug treatments and US $18.5 million in diagnostics/laboratory equipment. These values include all costs associated with orders: goods, procurement agent fees, freight, quality control, pre-shipment inspection and insurance.

In 2012, GDF delivered 39 383 treatments for MDR-TB patients. This was double the number of MDR-TB treatments supplied in 2011 (see chart below). GDF also supplied 1 067 087 treatments for patients with drug-susceptible TB, including 162,000 treatments for children.

Since 2001, GDF has supplied a total of 21 880 991 patient treatments.

LABORATORY EQUIPMENT

2012 saw the scale-up of the Expand TB Project – a UNITAID-funded project implemented in partnership with the Global Laboratory Initiative (GLI) and the Foundation for Innovative New Diagnostics for the procurement, distribution and use of new TB diagnostic tools. GDF obtained WHO approval for the procurement of Gene Xpert machines with a value of up to 40 million, allowing GDF to make agreements to supply the machines to Uganda and Rwanda with World Bank funding. Together with experts



from the GLI, GDF developed new LED Microscopy Kits for supply in early 2012.

QUALITY ASSURANCE

GDF continued to engage with potential manufacturers in order to increase the number of quality-assured products and manufacturers.

In 2012, joint meetings with the United States Pharmacopeia (USP) Promoting Quality of Medicines program (PQM) and the WHO Prequalification Program were held to encourage additional manufacturers to become prequalified.

A record number of anti-TB medicines received WHO prequalification in 2012:

• 10 FLD Products from four manufacturers from India

• 9 SLD products from four manufacturers from India and the Republic of Korea.

STRATEGIC DIRECTION

In 2012 GDF adopted a new strategic direction, following the completion of several studies and analyses.

Key findings from this work included:

• GDF is the largest supplier of quality-assured TB products and has procured goods with a cumulative value of more than US $700 million over the past 10 years;

• GDF supplies FLD treatments representing around 40% of TB cases as well as MDR-TB notified cases

• GDF's pooled procurement of FLD has reduced treatment costs by about 30%, accounting for inflation in India

• GDF procurement agents fees are the lowest among peer organizations

The principles behind GDF's strategic future direction include:

• Aim for zero tolerance on stock-outs in countries

• Continue to further shape the market for more affordable prices with no compromise on the international quality standards of TB drugs

• Build on lessons learnt from the past and regular market dynamics research

• Incorporate new TB drugs and diagnostics within the GDF platform

• Promote innovative tools for forecasting, monitoring and evaluation and communication with partners

• Mobilize and catalyze partners' expertise, including in-country technical assistance programmes to improve service delivery

• Foster countries' shared responsibility, accountability and sustainability for supply chain systems strengthening, regulatory aspects and rational use

• Focus on country needs and feedback to improve operations

GDF's new strategic approach includes the decentralization of staff to regional offices, which will result in closer links to national programmes, more efficient provision of technical assistance and mitigatation of bottlenecks in drug supply. New mechanisms aim to reduce or practically eliminate stock-outs: a global strategic stockpile (GSS) and funds for advance order placement, and a flexible procurement fund (FPF) for both FLDs and SLDs. Under the reshaped strategy, GDF will continue to provide FLDs and SLDs. However, funds for grants of FLDs to GDF are diminishing and donors expect the Global Fund or country budgets to fill this gap. GDF will also serve as the data recipient of the Early Warning System of Stockouts (SIAPS). This new strategic approach was endorsed by the Stop TB Partnership Coordinating Board at its meeting in November 2012.

4.3 CHALLENGE FACILITY FOR CIVIL SOCIETY (CFCS)

The Stop TB Partnership's Challenge Facility for Civil Society (CFCS) provides grants of US $5000 to US$ 20 000 to small community organizations that are working to raise awareness about TB and empower communities to respond to the disease.

The grants support a wide variety of activities. Some grantees use media workshops to teach journalists about TB issues. Others train health workers who go from door to door referring TB patients for testing and treatment. In all cases, the CFCS encourages small grassroots responses that lay down a foundation for larger projects in the future.

In 2012, the 21 organizations who received fourth-round CFCS grants reported their results. Through direct engagement with communities—in sensitization workshops for example—their projects reached a total of 81 589 people with live-saving knowledge about TB. The grantees reached a further 324 184 people through media programming. The results of this outreach include increases in health-seeking behaviour in the project areas and the provision of TB test for hundreds of HIV positive people.

The CFCS launched a fifth call for proposals on 1 August 2012 and received 380 applications. The 11 grantees for this fifth round were announced in December.

Summary of fourth-round results:

81, 589	Beneficiaries reached
299	Trainings/ sensitization meetings organized
378	Community volunteers trained
309	TB and former-TB patients engaged and empowered
102, 465	Information packs distributed
324, 184	People reached through media programming
3,262	People screened for TB
15, 013	15, 013 People referred for TB testing

4.4 GLOBAL FUND: ENGAGEMENT IN UNPRECEDENTED EFFORTS AROUND ADVOCACY FOR AND WITH THE GLOBAL FUND

In 2012, the Stop TB Partnership Secretariat engaged in unprecedented efforts around advocacy for and with the Global Fund. The Partnership is represented in the Global Fund Board, Phase 2 panels and TB Diseases committees of the Global Fund. Through our representation on the Global Fund phase 2 panel since 2012, between Wave 5 and 10 of second phase grant renewals the following were collectively achieved:

• Additional funds (over and above what CCM had asked) were approved for Bangladesh – 10 million USD additional for expanding case finding and new diagnostics through civil society PR in order to promote greater impact of the grant. This was unprecedented in TB grants in second phase.

• Additional funds earmarked for TB/HIV in the HIV grant of Nigeria and TB grant of Nigeria reprogrammed towards higher impact scale up of MDR-TB and PPM services.

• Advocacy efforts resulted in both TB and HIV grants being discussed together in one session. The issues raised in this meeting resulted in the Global Fund Secretariat calling a joint TB/HIV disease.

• DPR Korea, Tajikistan and Lesotho reprogrammed grants were supported with inclusion of new diagnostics and MDR-TB scale up.

• In Wave 11, a new approach for Pakistan was attempted to top-up the grant to achieve full coverage, including PPM, case finding intervention and massive PMDT scale up.

The Partnership Secretariat is also working very close with the Strategy Committee (SIIC), and even though the Partnership is not a member of the committee the Partnership Secretariat works through TB supporters in SIIC to brief and interact with them to provide the best advice and information.

The Partnership Secretariat worked hard, together with colleagues from WHO to contribute in developing various elements of the new funding model – disease score and country funding envelopes, strategic

investment framework, funding bands - ensuring that TB perspective was heard. Many partners came together around the Global Fund to voice concern over the proposed funding model for decision at the Global Fund Board meeting in September. A document was prepared to represent the reaction of the TB Community represented by the WHO Stop TB department and the Stop TB Partnership. This was circulated to partners, many of whom signed in support of the position.

The Partnership Secretariat engaged into a unique approach for collaboration with the Communities constituency at the Global Fund, and signed an agreement for joint work in support of TB advocacy among the members of the Global Fund Board and their constituencies. The interaction with the Secretariat of the Global Fund is much strengthened – also because of a better approach of the Global Fund Secretariat to the work with partners - and the Partnership Secretariat has very recently established clear working relationships with the CCM and Advocacy teams of Global fund.

The informal Global Fund TB Friends platform increased in the number of partners, and is expected to move to a different level by formalizing and developing it in a more rigorous manner as part of the Secretariat's operational strategy. Activities in Kuala Lumpur during the Union meeting and the Stop TB Board represented the best example of the efforts to increase the visibility around TB. Having the Health Minister Xaba of Swaziland in our Global Fund constituency seat and having him championing over strategic objectives ensured that the TB voice was heard loud and clear.

4.5 WORKING GROUPS: 2012 HIGHLIGHTS

a) Working Group on New TB Vaccines

Tuberculosis Vaccines: A Strategic Blueprint for the Next Decade, developed by experts in TB vaccine research, was published in March as a special issue of the journal Tuberculosis to provide a unified global strategy for TB vaccine development. It sets out a renewed, intensified and well-integrated international effort to develop more effective TB vaccines

as quickly and cost-effectively as possible to maximize limited resources. The Blueprint outlines scientific challenges and priorities and describes the critical activities and crucial questions that need to be addressed to develop life-saving TB vaccines for those who most need them. The Blueprint was developed through a year-long consensus process that was initiated at the Second Global Forum on TB Vaccines in September 2010.

b) Working Group on New TB Diagnostics

The Working Group, together with the University of Otago, conducted a literature review on latent tuberculosis infection (LTBI) designed to provide guidance on the development of the next generation of diagnostic tests for LTBI.

The Working Group also worked with the ACSM subgroup to conduct an analysis of the role of affected communities and community representatives in developing, implementing and monitoring policies and services on TB diagnostics. The analysis concluded that the patient community needs support in order to improve knowledge and strengthen its capacity to understand policies and guidelines on TB diagnostics.

c) Working Group on New TB Drugs

In 2012, several new TB drugs and candidates advanced in clinical development. Janssen's MDR-TB drug Bedaquiline (SituroTM) received accelerated approval from the US Food and Drug Administration, the first TB therapy with a new mechanism of action to be approved in 40 years. Otsuka filed for approval of its MDR-TB drug Delamanid with the European Medicines Agency with a decision expected in 2013. Two studies of combination drugs began in 2012. The second clinical trial of the regimen PA-824, moxifloxacin, and pyrazinamide, was launched in March 2012 and is testing the efficacy of the regimen in drug-sensitive and multidrug-resistant patients. A third clinical trial, started in October, is evaluating PA-824, TMC-207, pyrazinamide and clofazimine in combinations.

d) Working Group on MDR-TB

In 2012, RESIST-TB, a spin-off of the Research Subgroup of the main subgroup, published two drug efficacy articles in leading Oxford journals that provided important and timely research recommendations for optimizing future MDR-TB treatment regimens. In collaboration with the Critical Path to TB Drug Regimens Working Group, RESIST-TB published a White Paper in the International Journal on Tuberculosis and Lung Disease on the compassionate use of new drugs for DR-TB, highlighting six important steps for successful early access programs. The newly appointed External Relations sub-Group advocated on behalf of the accelerated approval of bedaquiline, which was subsequently approved by the US Food and Drug Administration.

There were two Global Green Light Committee meetings in 2012. Meeting reports are available on the WHO website.

e) TB/HIV Working Group

TB/HIV received considerable global visibility in 2012, including for research priorities and for the scale-up of life-saving interventions. The International AIDS Society Conference, ICASA and CROI 2012 all had record breaking numbers of well-attended TB/HIV sessions.

The revised WHO policy on collaborative TB/HIV activities was launched in March 2012, representing joint efforts by WHO and Working Group members to consolidate the latest evidence for galvanising further implementation and scale-up.

By the end of 2011, 119 countries reported testing more than half of their TB patients for HIV, resulting in some 2.5 million TB patients knowing their HIV status. Results were particularly impressive in the African Region where almost 70% of TB patients knew there HIV status. The gap, however, between diagnosis and treatment needs to narrow. Despite WHO guidelines to treat all TB/HIV patients regardless of CD4 count, only 48% of TB/HIV patients received live-saving ART in 2011.

Thanks largely to extensive scale-up in South Africa, coverage of Isoniazid preventive therapy more than doubled from 204,802 in 2010 to 446,598 in 2011 but this represents just 18% of all people living with HIV.

f) Childhood TB Subgroup

In May, the childhood TB Subgroup, WHO/AFRO and the Desmond Tutu TB Centre, University of Stellenbosch, organized a training session on Childhood TB. The objectives of the training were to increase case-finding of child TB cases in the community; improve the management of children with TB; increase the implementation of child contact screening and preventive therapy; and improve the quality of data on childhood TB. Following the session, country representatives developed future plans towards accelerating Childhood TB care and control in their respective countries, including a schedule of planned actions.

g) Global Laboratory Initiative

The Working Group mentored four national TB reference laboratories, assisting them to become fully functional Supranational Reference Laboratories (SRLs). A SRL taskforce group was established to help improve the functioning of the SRL network, strengthen existing SRLs and new SRLs and foster coordination of technical assistance to high-burden countries.

The GLI's "Stepwise Process" on TB laboratory accreditation was rolled out and harmonized with other tools designed to improve laboratory quality. In early adopter countries, National TB Reference Laboratories have made considerable progress towards accreditation. The GLI tool is available online at www.GLIquality.org.

4.6 GOVERNANCE

a) 2012 overview

In 2012 the Coordinating Board oversaw the development of the Operational Strategy 2013-2015 which was approved at its meeting in November in Kuala Lumpur, Malaysia. The Board also oversaw a number of governance reforms, including reforms to the Board itself as well as key decision-making structures which support it.

b) Meetings of the Board

The Coordinating Board held its 21st meeting in Bangkok, Thailand, from 30 January to 1 February 2012. The meeting was preceded by a one and a half day retreat on governance during which the Board discussed proposals for streamlining its composition and making it more representative of a wider range of constituents.

Key highlights were the following:

• Board members applauded the vision and leadership of the TB Ministerial Champions (the Ministers of Health of Lesotho, South Africa and Swaziland) on the issue of TB in the mining sector in Southern Africa.

• The Board requested the Stop TB Partnership to work with UNAIDS to update the Memorandum of Understanding between the two organizations.

• Board mandated the development of the Operational Strategy 2013-2015.

• The Board formed an Expert Advisory Group to advise the Global Drug Facility.

The Coordinating Board held its 22nd meeting in Kuala Lumpur, Malaysia, from 18 to 19 November 2012.

At the meeting, Board Members:

• Approved the Operational Strategy 2013-2015.

• Approved a new organigram for the Stop TB Partnership Secretariat.

• Decided to implement a set of recommendations regarding the Board's composition.

• Endorsed the "Zeros" campaign.

• Requested that the Executive Committee review the number and structure of the Working Groups.

• Endorsed the recommendations of the TB REACH Proposal Review Committee.

• Endorsed the new strategic direction of the Global Drug Facility.

• Acknowledged the urgent need to position TB in the post 2015 development agenda.

STOP TB PARTNERSHIP SECRETARIAT FINANCIAL MANAGEMENT REPORT

SUMMARY STATEMENT OF INCOME AND EXPENDITURE FOR THE YEAR ENDING 31 DECEMBER 2012

(ALL FIGURES IN US$ '000)

	2011	2012
INCOME		
Voluntary contribution		
Governments & their Agencies[1]	76, 649	50, 763
Multilateral organizations	15, 030	11, 440
Foundations and others[2]	3, 748	562
In kind contribution		
In kind contribution for drugs (Novartis)	-	2, 319
Other income and adjustments		
WHO In kind contribution	56	56
Prior year adjustment to income from voluntary cash contribution[3]	6, 537	(973)
TOTAL INCOME	**102, 020**	**64, 167**
EXPENDITURE		
Partnership Building[4]	12, 797	6, 137
Advocacy and Communication	2, 399	2, 270
Global Drug Facility (GDF)[5]	64, 984	33, 381
TB REACH[6]	21, 314	20, 153
General Management and Administration[7]	5, 498	4, 018
TOTAL EXPENDITURE	**106, 992**	**65, 959**
Transfer to reserve	2, 000	0
BALANCE OF INCOME OVER EXPENDITURE FOR THE YEAR	**(6, 972)**	**(1, 792)**

Figures in these statements are for management discussions and have not been certified by WHO.

The above summary statement does not include GDF Income and Expenditure pertaining to Direct Procurement, as these funds do not pass through the TBP.

[1] The 2012 Income for Governments & their Agencies appears substantially decreased as CIDA contribution for 2012 (US$ 24.1 m) was received in advance and accordingly reported in 2011.

[2] The 2012 Income for Foundations and others appears substantially decreased as contribution from Global Fund (US$ 2.45 m) which was received by TBP on behalf of STOP Department in 2011, was now directly received by STOP TB Department in 2012.

[3] The Prior Period and other adjustments exist to align WHO records and TBP records for reasons such as difference in recognition period etc.

[4] The decrease in 2012 expenditure figures for Partnership Building is consequent to expiry of the term of the agreements to receive funds on behalf of partners and transfer to them (approx. US$ 6 m in 2011).

[5] The expenditure figures for GDF Grant Procurements represent the amount of orders placed in 2012.

[6] The income and expenditure for TB REACH includes procurement of GENEXPERT Machines for Grantees through GDF. This income and expenditure is excluded from GDF figures in the above consolidated statement to avoid double accounting. The funds (US$ 3.7m) were channelled through GDF only as a procurement mechanism.

[7] General Management and Administration expenditure includes PSC charge deduced as per expenditure figures taken in above report.

STOP TB PARTNERSHIP
GLOBAL TB DRUG FACILITY
FINANCIAL MANAGEMENT REPORT
STATEMENT OF INCOME, CONTRIBUTIONS RECEIVED FOR DIRECT PROCUREMENT AND ITS EXPENDITURES
(US$ '000)

	2011	2012
INCOME		
Voluntary contribution		
Governments & their Agencies	33, 506	19, 685
Multilateral organizations	14, 420	10, 830
Foundations and others	93	66
In kind contribution		
In kind contribution for drugs (Novartis)	-	2, 319
Other income and adjustments		
Transfer from TB REACH for special direct procurement	6, 411	0
Contribution for direct procurement	96, 672	116, 265
Prior year adjustment	4,758	0
TOTAL INCOME AFTER PRIOR YEAR ADJUSTMENT	**155, 860**	**149, 165**
EXPENDITURE		
Grant procurement of Anti-TB drugs[1]	51, 382	27, 902
Special direct financing of procurement	6, 782	1, 352
Direct procurements	96, 672	116, 265
Quality assurance and prequalification	846	813
Technical assistance, Monitoring and Salaries	4, 863	1, 760
Advocacy and Communications & Management	424	1, 554
Fund transferred to Stop TB Department	687	-
Indirect costs (WHO Programme Support Costs)	1, 196	1, 220
TOTAL EXPENDITURE	**162, 852**	**150, 866**
BALANCE OF INCOME OVER EXPENDITURE FOR THE YEAR	**(6, 992)**	**(1, 701)**

Figures in these statements are for management discussions and have not been certified by WHO.

[1] The expenditure figures for GDF Grant Procurements represent the amount of orders placed in 2012.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Stop TB Partnership
www.stoptb.org

World Health Organization
Global TB Programme
www.who.int/tb

20, Avenue Appia
CH-1211 Geneva 27

Printed by the
WHO Document Production Services
Geneva, Switzerland

Designed by Tashira Muqtada
The Bright Sun
www.thebrightsun.com

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