Stop TB Partnership

DOC 2.06-8.1

PROPOSED FRAMEWORK FOR MONITORING AND EVALUATION OF IMPLEMENTATION OF THE GLOBAL PLAN

1. Introduction

The Global Plan to Stop TB must remain relevant for the Partnership throughout the Plan's lifetime (2006-2015). As we work towards achieving the Partnership's targets for 2015, regular assessment of progress in implementing the activities set out in the Plan is necessary to guide our ongoing efforts. The occurrence of extensively drug-resistant TB (XDR-TB) highlights the urgent need for speeding up the development of new tools and for an increased focus on translation of the Global Plan's strategic directions into operational plans at country level. The development of country-level operational plans and review of progress so far in implementing the strategic plans of the implementation Working Groups should inform any adjustments necessary in these plans. Furthermore, one of the issues emerging from the review of the Working Groups is the way in which monitoring and evaluation can serve the purpose of providing accountability for the Working Groups' activities,

The Partnership Secretariat has therefore developed a proposed framework for monitoring and evaluation of implementation of the Global Plan. The Secretariat of the Stop TB Partnership and the Working Groups have key roles to play in monitoring and evaluating the overall Global Plan and the individual Working Group strategic plans.

2. Objectives of the proposed approach to monitoring and evaluation

- To report on progress in the implementation of each individual Working Group's strategic plan;
- To compile the reports on progress of all the Working Groups and the Secretariat;
- To develop the overall report on progress in the implementation of the Global Plan based on the progress reports of the Working Groups and the Secretariat.

3. Methodology

The Secretariat's role is to facilitate the process of monitoring and evaluating the implementation of the Global Plan. A proposed standard template[1]1 has been developed by the Secretariat to promote a coordinated approach to compiling the overall progress report on Global Plan implementation, based on the progress reports of the individual Working Groups. The template employs a standard terminology which includes the objectives, activities, products, indicators and milestones of each Working Group's individual strategic plan.

4. Proposed roles of the Partnership Secretariat and the Working Groups

For each Working Group, the Chair and Secretary should consult to identify a focal point for monitoring and evaluation, whose role in collecting and presenting data, and analysing results will be vital to the success of ongoing monitoring and evaluation.The focal point for monitoring and evaluation in the Partnership Secretariat, Rachel Bauquerez, will work with the focal point for monitoring and evaluation in each Working Group to facilitate the contribution of each Working Group to the process..

5. Presentation and dissemination of the results

1 See: http://www.stoptb.org/cb/meetings/20061129_Jakarta_Indonesia/default.asp

The Partnership Secretariat and the Working Groups will be jointly responsible for the presentation and dissemination of the results of monitoring and evaluation of implementation of each individual Working Group's strategic plan, and therefore collectively of the overall Global Plan. The advice of the Coordinating Board will be sought on the frequency of reporting and on disseminating the results.

6. Standard structure for the monitoring and evaluation of the implementation of the Global Plan

The table shows the standard structure for monitoring and evaluation proposed for use in relation to Global Plan implementation.

CONTEXT
The Working Groups: R&D (Diagnostics, Drugs and Vaccines), Implementation (DOTS Expansion, TB/HIV and MDR-TB) and ACSM. The STOP TB Partnership Secretariat; The Global Plan;

INPUT	**PROCESS**	**OUTPUT**	**OUTCOME**	**IMPACT**
Basic resources needed The strategic plan of each individual Working Group; the Global Plan; financial resources; staff and staff time of the Working Groups and external consultancy (when necessary).	***Working Groups' activities and indicators*** M&E meetings. Facilitation of interaction with and between the WGs. Data collection. Management.	***Results of the Working Groups' activities.*** Measurement of the work of the WGs.	Progress towards targets. Presentation and dissemination of data.	Measurement of achievement of impact of the Working Groups' activities.
Monitoring/ Process Evaluation			Outcome/Impact Evaluation	

7. Summary of the monitoring and evaluation parameters for the Working Group strategic plans

Information extracted from each individual Working Group's strategic plan and from the Secretariat's strategic plan has been compiled as shown in Annex 1. This information includes the strategic vision, the milestones and overall objectives and the monitoring and evaluation process of each Working Group. In order to facilitate compilation of the overall Global Plan progress report based on the progress reports of the individual Working Groups, the format is standardized across the Working Groups using standard monitoring and evaluation terminology.

8. Standard templates

Monitoring and evaluation parameters have been extracted from each individual Working Group's strategic plan. A standard terminology has been used i.e. objectives, activities, products, indicators and milestones. Each working group focal point, in collaboration with the focal point at the Secretariat will be responsible for completing or modifying this working document. All individual draft templates have posted on the Stop TB website for reference and comment[2]

2. See: http://www.stoptb.org/cb/meetings/20061129_Jakarta_Indonesia/default.asp

Annex 1. Summary of monitoring and evaluation parameters for the Working Group strategic plans

Research and Development Working Groups

1. New TB Diagnostics WG

Strategic vision

The vision of the Stop TB New Diagnostics Working Group is to develop and introduce cost-effective and appropriate new diagnostic tools that will contribute towards improved control of the global TB epidemic and improve the quality of patient care.

The ideal toolbox would contain diagnostic technologies, all of which perform equally well in HIV-infected subjects, to

1. improve TB case detection both through high sensitivity/specificity and improved accessibility – simple, accurate, inexpensive, same day, near-patient products would be the ultimate goal

2. rapidly and inexpensively identify drug resistant TB disease enabling timely effective patient treatment to reduce both individual morbidity and continuing transmission

3. reliably identify latent TB infection and define the risk of future progression to active disease enabling rational use of preventive therapy in appropriate subjects

Milestones

The Strategic Plan of the Working Group addresses the needs at the different levels of the health care system sequentially, thus allowing rapid implementation of novel technologies where technical hurdles are less pronounced (i.e. regional reference centres) whilst development continues of more "perfect" solutions for introduction in settings closer to the patient (local microscopy centre or even health post). The plan aims to achieve the following three **milestones**:

1. **By 2008** the Group plans to introduce an easy-to-use technology with accuracy similar to culture but capable of providing results in a few hours (or days) instead of weeks. This product will be implemented at the first referral level (district laboratories) and to some extent also in peripheral labs (microscopy centers).

2. **By 2010** new tests for detection of active TB in a point-of-care (POC) setting, for example for use by rural health workers, will be available. Compared to smear microscopy, such tests will be more sensitive, much simpler and still as affordable. POC may be defined as i) instrument free device requiring minimal training or ii) hand held simplified instrument that requires minor training. Possible candidates may be based on lateral flow technologies, integrated, portable nucleic-acid test system or gas sensor technologies.

3. **By 2012** a rapid diagnostic procedure capable of predicting the future progression of latent TB infection to active disease, in both HIV-infected and uninfected subjects, will be introduced.

Monitoring and evaluation process:

Progress towards the overall goals of producing new diagnostic tools, as envisaged above, will be reviewed against the targets and timelines described at annual meetings of the Working Group. Dedicated secretariat staff will continuously monitor progress and highlight bottlenecks and problems at the annual meetings of the Working Group, or to appropriate individuals or subgroups.

2. New TB Drugs WG

Strategic vision

To achieve its vision, the Working Group on New TB Drugs (WGND) has identified the following areas of strategic importance:

- basic discovery biology to identify and validate new targets and identify candidate compounds using effective screens and creative medicinal chemistry;
- drug development;
- more effective clinical trial planning and execution, including identification of improved biomarkers and methods of assessing latent disease; and
- clear and efficient regulatory guidance.

Milestones

The WGND envisions an environment by 2015 that will allow for the sustained development of new TB drugs that can ultimately be combined into completely novel and revolutionary TB regimens. One of the lessons learned since the introduction of the existing anti-TB drugs is that continued worldwide commitment, research and vigilance to ensure a consistent pipeline of new antimicrobials will be required to eradicate tuberculosis in the 21st century.

Monitoring and Evaluation process:
Annual map progress among the partners and other entities that may enter drug development for TB. A database of projects, compounds, and clinical trials will be established to survey the current status worldwide.
The careful monitoring and evaluation of a large number of clinical trials is expensive. Modest initiatives to expand this capacity are underway at WHO/TDR, but are unlikely to satisfy the demand created by the initiation of multiple regulatory-quality TB clinical trials. The development of international monitoring standards and increased global monitoring ability are needed to assure that promising agents are not impeded in their progress towards registration and utilization to curtail the global TB epidemic.

3. New TB Vaccines WG

Strategic vision
The aim of the Stop TB Partnership's Working Group on New TB Vaccines Development is to foster and coordinate collaborative efforts to develop novel vaccination approaches that are effective in reducing TB disease. It is probable that the next generation of vaccines will work by complementing the immune response induced by the current BCG vaccine.
The strategic vision of the Working Group is that improved vaccines and vaccination strategies will make a crucial contribution to achieving the Stop TB Partnership's target for 2050 of reducing the global incidence of TB disease to less than 1 case per million population.

Milestones
The overall objective of the Working Group for 2006-2015 is to have a safe, effective, licensed vaccine available at reasonable cost by 2015.

In the overall workplan for 2006 – 2015, the **first target** is that at least 20 vaccine candidates will have entered phase I clinical trials by 2015. It is anticipated that multiple candidates will progress through clinical trials in a parallel manner and that unsuccessful candidates will be have to be replaced continually by new entrants.

It is anticipated that phase II trials of the first candidates will be well underway in **2006**. Initial phase II trials will take approximately 3 years, with an expected reduction to 2 years following

development and refinement of trial protocols and immunological assays. **The second target** is that 9 candidates will be evaluated in phase II trials. Furthermore, by **2008 t**here will be at least two vaccines in phase IIb or 'Proof of Concept' (PoC) trials which will provide some early indication of efficacy and therefore significantly reduce the risk of failure in phase III.

The first phase III trials could begin as early as **2010**. They will test vaccine candidates' ability to act as pre-exposure vaccines and will take 4 years to complete. Post-infection trial protocols will be available from **2011** and are expected to take **3 years for completion**. **The third target** for the Global Plan is to carry out a total of four phase III efficacy trials.

Approximately two years will be required to complete licensing procedures and to begin to distribute a successful vaccine. The final target is to have a safe, effective, licensed vaccine available at reasonable cost by 2015.

Monitoring and evaluation process

Progress towards the overall goal of producing an effective vaccine by 2015 will be reviewed against the targets and timelines set out above at annual meetings of the Working Group. Dedicated secretarial staff will monitor progress on a continuous basis and highlight bottlenecks and problems at the annual meeting of the full Working Group, or to appropriate individuals or sub-groups. The development of international monitoring standards and increased global monitoring ability are needed to assure that promising agents are not impeded in their progress towards registration and utilization to curtail the global TB epidemic.

Implementation Working Groups

1. DOTS Expansion WG

Strategic vision

STOP TB Strategy

1. **Pursuing quality DOTS expansion and enhancement, through:**
(i) Political commitment, with long-term planning, adequate human resources, expanded and sustainable financing, to reach the targets set by the World Health Assembly and the Stop TB Partnership. (ii) Case detection through quality-assured bacteriological testing (microscopy, culture, DST) and strengthening of the laboratory network to facilitate detection of sputum smear-positive, sputum smear negative, drug-resistant and MDR-TB cases.
(iii) Standardized treatment, under proper case management conditions, including directly observed treatment to reduce the risk of acquiring drug resistance, and support of patients to increase adherence to treatment and chance of cure.
(iv) An effective and regular drug supply system, with improved drug management capacity.
(v) An efficient monitoring system for programme supervision and evaluation, including measurement of impact.

2. **Addressing TB/HIV, MDR-TB and other special challenges**, by scaling up TB/HIV joint activities, DOTS Plus, and other relevant approaches.

3. **Contributing to health system strengthening**, by collaborating with other health programmes and general services in, for example, mobilizing the human and financial resources needed for implementation and impact evaluation, and by sharing and applying achievements of TB control.

4. **Involving all care providers**, public, nongovernmental and private, by scaling up approaches based on a public-private mix, to ensure adherence to the International Standards for TB Care, with a focus on health providers used by the poor.

5. **Engaging people with TB and affected communities**, by scaling up community TB care and providing opportunities
for meaningful involvement of patients and communities in increasing awareness, demanding high-quality services,
supervising treatment, and reducing stigma.

6. **Enabling and promoting research** to improve programme performance and to develop new drugs, diagnostics and
vaccines.

Milestones

Improving DOTS quality
All countries provide high-quality diagnosis and treatment and achieve ≥85% treatment success rate by 2015

Instituting and scaling up PPM DOTS
All countries have developed guidelines, by 2010, for the involvement of relevant public and private health-care providers in DOTS, and have implemented them by 2015

Scaling up community DOTS
All countries in Africa have scaled up community DOTS initiatives by 2010

Introducing and scaling up PAL

PAL is introduced in 20% of developing countries by 2010 and in 50% by 2015

Developing capacity for culture services DST and new diagnostics
1. All countries have developed full capacity by **2015** to perform culture and DST according to national policies
2. From **2010**, new diagnostic tools will be implemented gradually and expected to cover at least 50% of the eligible population by **2015**

Prioritizing the need of poor and vulnerable populations
1. All countries have developed capacity by **2010** to monitor the extend to which DOTS reaches and serves poor and vulnerable

2. By **2010** all countries have developed key strategies for improving access to DOTS for poor and vulnerable populations

Monitoring and evaluation process
TB control and equity outcome
The core indicators for measuring achievements in relation to outcome **objective 1** is the well-established indicators of case detection rate and treatment success rate. A combination of improvements to the existing recording and reporting system, mechanisms to improve notification systems as well as better approaches to estimate underlying incidence would improve the quality of these indicators.

In order to assess achievements in relation to the 2nd objective, the case detection and treatment success indicators could be measured separately for different subgroups according to age, sex, socioeconomic class, etc. For example, the target could be that at least 70% people from the poorest segment of society who suffer from TB should be detected under DOTS and that at least 85% of them are successfully treated. To measure this, information about socio-demographic profile need to be collected as part of **prevalence surveys as well as through sample surveys of patients registered in DOTS programmes.** Alternatively, case detection and treatment success rate could be disaggregated by poor vs. non-poor geographical areas.

Process of implementing DOTS expansion activities
Process indicators to measure progress towards quality TB management already exist. Additional indicators to measure process of implementing PPM DOTS, Community DOTS, PAL, Culture and drug susceptibility testing services and Pro-poor strategies (see below) will have to be further developed.

Contribution towards MDG targets
In order to measure progress towards MDG targets, baseline and follow-up **prevalence surveys** and/or other studies that can provide reliable estimates on incidence, prevalence and death rates need to be undertaken. Through collecting data on socioeconomic variables in prevalence surveys, TB epidemiology could be described and MDG targets monitored for different socioeconomic groups, i.e. each MDG indicator can be disaggregated by socioeconomic group. It should be noted that DOTS Expansion is one of many factors that will determine future changes in TB incidence, prevalence and death rate. Therefore, measuring changes in these parameters is not the ideal approach to assess successes attributable to DOTS Expansion, but rather to assess the combined impact of the full package of intervention outlined in the Global Plan to Stop TB 2006-2015 as well as the "up-streams" determinants of the TB epidemic such as poverty alleviation and general social and economic development.

2. TB/HIV WG

Strategic vision

The **strategic vision** of the TB/HIV Working Group for 2006–2015 is to reduce the global burden of HIV-related TB through effective collaboration between TB and HIV programmes and communities, and evidence-based collaborative TB/HIV activities, to achieve the global targets for 2015, including the MDG and Stop TB Partnership targets for TB and HIV. The vision is rooted in the new WHO Stop TB Strategy.

The **mission** of the TB/HIV Working Group is to develop an effective, evidence-based policy to reduce the impact of HIV-related TB and to promote, monitor and evaluate the global implementation and impact of this policy.

Milestones

The TB/HIV Working Group strategic plan lays out the activities that need to be undertaken by the WG and its partners over the next ten years to achieve the 2015 targets under the following four objectives:

1. Scale up and expand collaborative TB/HIV activities.
2. Develop and coordinate implementation of research to improve the prevention, early diagnosis and rapid treatment of TB in people living with HIV and incorporate results into global policy.
3. Increase political and resource commitment to collaborative TB/HIV activities.
4. Contribute to strengthening health systems to deliver collaborative TB/HIV activities.

Monitoring and evaluation process

The guide to monitoring and evaluation (M&E) of collaborative TB/HIV activities defines the core indicators that are necessary for monitoring collaborative TB/HIV activities. Existing globally recommended data collection tools for TB and HIV/AIDS are being adapted to capture additional TB/HIV data. TB/HIV activities are now included in the global TB reporting system and should be included in the global AIDS reporting frameworks. The impact of TB/HIV activities will be measured in terms of existing impact indicators, such as TB mortality, TB incidence, and HIV incidence.

3. MDR-TB Working Group

Strategic vision

The vision of the Working Group on MDR-TB is to integrate drug resistance surveillance and the management of MDR-TB as routine components of TB control, providing access to diagnosis and treatment for all TB patients and covering all health care providers.

Milestones

Currently, less than **2%** of the estimated number of culture-positive MDR-TB patients are treated according to WHO recommendations. With the planned expansion of DOTS-Plus, it is envisaged that by **2015,** 56% of culture-positive MDR-TB patients will be detected and treated. During the 10-year period of the Global Plan, a cumulative 23% of all culture-positive MDR-TB patients will be treated under DOTS-Plus.

It is estimated that, during the Plan period, 778 000 MDR-TB cases will be treated according to WHO guidelines, 53% of them in the Eastern European Region, 19% in the South-East Asian Region, and 16% in the Western Pacific Region. Of these, 75% or 587 000 will be treated successfully. With the implementation of DOTS and DOTS-Plus, it is expected that the estimated global proportion of re-treatment cases will decrease from 20% in 2005 to 11% in 2015. Most importantly, it is expected that the number of MDR-TB cases will be reduced from an estimated 533 000 in 2005 to 193 000 in 2015, mainly as a result of reduction in incidence and in proportion of retreatment cases and as a combined effect of all TB control interventions. With the expansion of DOTS-Plus, it is expected that 142 000 deaths from MDR-TB will be averted between 2006 and 2015

Monitoring and evaluation process

The global MDR-TB situation is monitored by the WHO/IUATLD global DRS project and data are published every three years. In addition, MDR-TB estimates have been published and are being updated regularly. DOTS-Plus programme performance is currently monitored by WHO and the GLC. An inventory of second-line drug use in public and private sectors will be conducted in 2005.
The SNRL started in conjunction with the WHO/IUATLD global DRS project and is composed of twenty-three TB laboratories conducting annual proficiency testing on itself. This network is also responsible for the quality-assurance of DST in NRLs worldwide.
A DOTS-Plus recording and reporting system has recently been developed which allows managers at different levels of NTPs to monitor overall DOTS-Plus programme performance. In the future, elements of this system will also be included in the DOTS recording and reporting system at district level.
As the DOTS strategy is evolving to include all TB patients, MDR-TB notifications and treatment outcomes should become part of the annual WHO report: Global Tuberculosis Control: surveillance, planning and financing.
Monitoring to evaluate progress in MDR-TB control will also be performed in collaboration with partners and WHO Region and Country staff during routine technical missions.
Finally, annual or semi-annual meetings of the Stop TB Working Group on DOTS-Plus for MDR-TB will take place to review the progress made in global DRS and MDR-TB control and give strategic direction on future activities. The Working Group will also monitor funding and expenditure on the global coordination costs for DOTS-Plus scale-up during the planning period.

The ACSM Working Group

Strategic vision

The success of the Partnership's Global Plan to Stop TB for 2006–2015 will rest on the ability of ACSM efforts to generate political, social, and behavioural change at all levels. There is an urgent need to expand ACSM in donor and endemic countries, directed at rapidly building and financing a multilevel, multisectoral social movement to reverse the TB epidemic and achieve the Millennium Development Goals and the Stop TB Partnership's targets. While the Working Group's principal focus in this summary plan is on developing ACSM strategies in support of existing global TB targets, the ACSM Working Group's strategic vision is to achieve TB-free communities by:

(1) Global advocacy: creating the political accountability and social pressure required to shape policy agendas and
mobilize US$56 billion from 2006 to 2015 for TB control and new tool development; and

(2) Country-level ACSM: establishing and funding evidencebased and innovative country- and community-driven ACSM
activities to effect sustainable societal and behavioural change at the national, subnational and individual level, aimed
at ensuring access to treatment and care for all, particularly the poor, vulnerable and hard-to-reach populations.

Milestones:

Global advocacy

• By **2010**, civil society TB advocacy organizations or coalitions will be functioning in 20 donor countries and 40 endemic countries.

• By **2015**, the ACSM Working Group will have helped to mobilize US$56 billion for the control of TB and the development of new tools in accordance with the Partnership's Global Plan in order to achieve the Millennium Development Goals and
meet the Stop TB Partnership's targets.

Country-level ACSM

• By **2015**, multisectoral, participatory ACSM methodology will be a fully developed component of the WHO Stop TB
Strategy.

• By **2015**, all priority countries will be implementing effective and participatory ACSM initiatives.

• By **2008**, at least 10 endemic countries will have developed and will be implementing multisectoral, participatory ACSM initiatives and generating qualitative and quantitative data on the contribution of ACSM to TB control.

• By **2010**, at least 20 priority countries will be implementing multisectoral, participatory ACSM initiatives, and monitoring and evaluating their outcomes.

Monitoring and evaluation process

The Working Group will coordinate monitoring and evaluation efforts to measure the outcomes of global, regional and national ACSM efforts and their contributions to TB control. Existing information and data collection systems, methods, and indicators will be used to generate and evaluate various data. The Working Group will also develop a core set of indicators for inclusion in existing formal data collection systems and a participatory process for measuring the impact and cost-effectiveness of ACSM activities at all levels. At the global level, the Working Group will commission reviews to analyze progress towards building ACSM capacity and the achievement of the Global Plan to Stop TB. At the country level, ACSM should be included as a component of all national TB programme reviews. Working Group meetings and other meetings of international, regional and national-level stakeholders will be held to track progress, disseminate evidence on good practices and lessons learned, and modify the ACSM strategy and activities when necessary.

The Stop TB Partnership Secretariat

Strategic vision

The Secretariat's strategic vision is that the full and active contribution of all partners to TB control and poverty reduction will lead to a TB-free world by 2050. Its mission is to empower partners in sustained action, to create synergies and to catalyse innovation, in order to achieve the Partnership's 2015 TB targets linked to the MDGs.

The Secretariat is a facilitator and broker for partners, a stimulator of innovation, a communicator on progress and an ambassador for Stop TB. It is not a programme manager, a funding agency or a policy-maker.

Milestones

Financial resources and accountability and financial management

Targets to 2015:

- To strengthen the Secretariat's reputation for accountable, flexible and well-coordinated management of resources
- To mobilize the resources needed to enable the Partnership to fully implement the Global Plan to Stop TB (2006-2015)

A Secretariat that can rise to the challenge of brokering a growing pool of resources requires strong management skills.

In particular, development of the Partnership Trust Fund to secure the funding requirement for all core areas of Secretariat
activity will be fundamental. By 2015, the Fund should reach a cumulative US$500 million.

The Partnership will secure 10% of Global Plan funding requirements by 2007, 25% by 2009, 50% by 2011 and 100% by 2015. A long-range resource action plan will ensure consistent and effective donor engagement. In addition to nurturing existing donors, the Secretariat will aim to realize 10% of its income from new donors by 2011. It will develop constructive relations with the private sector, securing a public/private funding ratio for Secretariat activities of 80/20 by 2015.

The Secretariat will stimulate the mobilization of sufficient financial resources to ensure the implementation of Secretariat functions, provide seed funding for national partnerships, provide catalytic financial support to the working groups, and support the effective evolution of special initiatives such as the GDF.

The Secretariat will grow the pool of available funding for technical assistance, at the same time as brokering technical advice on proposals and resource mobilization to countries and partners, as required – notably in support of interaction with international financial mechanisms (such as GFATM). It will establish a tracking and early warning system to inform partners of funding opportunities.

Access to TB drugs

By **2015**, The GDF will provide a cumulative total of 25 million patient treatments through both grant and direct procurement service lines and support for access to quality affordable anti-TB drugs will be provided in all countries where there is need. The GDF will stimulate the development of viable markets for TB control products, other than first-line anti-TB drugs.

By **2007**, the supply of anti-TB drugs through the GDF will meet the biennial target of patient treatments to be delivered globally, as identified by the DOTS Expansion Working Group.

In view of the close relationship between TB and HIV infection, the GDF will be prepared for the harmonized supply of TB/HIV preventive therapies by **2007** and possible TB/HIV treatment therapies by **2009**.

The longer-term aim is to support selfsufficiency in drug management at national and regional level through the implementation of the GDF's Sustaining the Gains Strategy and the establishment of a technical assistance service line to broker support from partners for countries in need. The strengthening of the GDF at regional level, to be completed by **2007**, will facilitate the process.
By **2011**, GDF systems will be prepared for the introduction of new drugs and new diagnostics. By **2015**, plans and service lines for new vaccines will be fully developed.

Partnership and external relation
Targets to 2015:
• An increased number and proportion of TB stakeholders will become active partners in Stop TB.
• Skills and resources will be available at regional and national levels to develop successful Stop TB partnerships.
• TB will be further mainstreamed into global and national development agendas.
• Pro-poor approaches will be mainstreamed into TB control.
• A unique brand for Stop TB will be accepted and promoted by all partners.

Drawing on Secretariat seed funding and technical support, **10 national partnerships** will be established by **2011** and an additional **12** by **2015**. The Secretariat will monitor and evaluate the effectiveness of partnerships to guide future development.

The Secretariat will organize at least **three Partners' Forum** meetings during **2006–2015.** It will also continue to organize meetings of the Coordinating Board at least twice a year, and of other executive bodies as required, to ensure that the mandate of partners is implemented.

The Secretariat will support the Advocacy, Communication and Social Mobilization Working Group in promoting the Global Plan as a living document, and strengthen linkages between advocacy, resource mobilization efforts and the mainstreaming of TB into development and political agendas. The Partnership Secretariat team currently acts as the secretariat of the ACSM Working Group, but this function may be transferred to a partner agency by **2009**.

Catalysing change and monitoring progress
Targets to 2015:
• TB control will reach beyond traditional disease control and will feature in wider health and socioeconomic development agendas.
• The Secretariat will be capable of supporting the retooling of partners, who require assistance, in preparation for the introduction of new products and new technologies.
• Progress against the milestones, targets and impact of the Global Plan and working group activities will be evaluated and documented

The Secretariat will catalyse change and debate in favour of enhanced TB control, through engagement with wider health sector strengthening and financing reform agendas, along with other social and economic development issues (such as poverty reduction, equity, gender, education, human rights, etc.). By **2007**, TB will be further mainstreamed into the health systems strengthening agenda at global level and in important regional debates on development issues. A gender perspective and a human-rights-based approach will be integrated into all key Secretariat activity areas, including advocacy and communications, resource mobilization, partnership-building and technical assistance. By **2009**, the Secretariat will facilitate a guide on the mainstreaming of human-rights-based approaches in TB programming. By **2011**, it will secure strategic alliances to promote human rights, equity and gender awareness in global TB programming and Secretariat activities.

The Secretariat will support the working groups in the promotion of patient-friendly new technologies and will identify opportunities and resources to enable innovative projects to be nurtured. By **2009**, it will develop a network to broker technical assistance to retool the Secretariat

and key partners and countries for the introduction of new technologies. By **2015**, the Secretariat will have the skill set necessary to support the implementation of the next Global Plan to Stop TB.

Monitoring and evaluation process

The Secretariat has a fundamental role in monitoring and evaluating the Partnership and the Global Plan to Stop TB (2006–2015). The Partnership Secretariat will report to the Partner's Forum (at least every 3 years) and Coordinating Board (annually) on progress towards the achievement of the Global Plan targets.

In coordination and collaboration with the working groups, the Secretariat will monitor and oversee working group inputs and measure progress against the targets of the Global Plan. The Secretariat will provide a progress report at each Partners' Forum. In addition, in **2011** the Secretariat will facilitate a midterm review and progress report. In **2015** it will provide a final report on the Global Plan to Stop TB (2006–2015) and facilitate development of a further Global Plan for the next period. The purpose of this monitoring and evaluation activity is to enable the Secretariat to propose tactical revisions that could add value and enable partners to implement innovative solutions to better deliver against the Global Plan targets.