

Independent External Evaluation of the Global Stop TB Partnership

REPORT

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REPORT OF THE INDEPENDENT EXTERNAL EVALUATION OF THE GLOBAL STOP TB PARTNERSHIP: EXECUTIVE SUMMARY

Overview

The Global Stop TB Partnership has established itself in a very short time as a widely respected global health partnership. The perception of partners themselves is that it has both added value to what they were already doing and has moved swiftly to introduce widely appreciated new initiatives such as the Global Drug Facility (GDF) and the Green Light Committee.

Relevance

TB remains a global health emergency. The strategic objectives of the Partnership's Global Plan to Stop TB were formulated specifically to address the main constraints to effective TB control identified in close consultation with high burden countries themselves. They are clear and well defined, and specifically directed towards the intended problems and policy priorities of the principal stakeholders (eg in relation to UN MDG targets and indicators).

Efficacy

The Partnership has scored some major achievements in only three years. It has built and is sustaining a broad network of partners; established a partnership architecture which commands broad support; heightened political commitment and marshalled widespread commitment to a detailed Global Plan to Stop TB; made significant progress against TB, even in difficult environments; highlighted work on new diagnostics, drugs and vaccines which are critical but working to longer timescales; and operationalised in a remarkably short time the Green Light Committee for second-line TB drugs and a complex Global Drug Facility covering grant-making, procurement and partner mobilisation for technical assistance for first-line drugs. This is a formidable record.

Efficiency

The evaluation concludes that the Stop TB Partnership does add value, that any value it does add will have large health benefits compared to the costs involved and also in comparison with other uses of funds since the Partnership is promoting extremely cost-effective interventions in DOTS, and that the net costs of the Partnership are low.

Commitment and challenges for the future

Strong commitment has been expressed by partners to sustaining the Global Stop TB Partnership. Its mission and strategy continue to command support, as it deserves. At the same time, the Partnership currently faces some challenges.

Only 16 countries have yet reached the World Health Assembly targets for 2005 which the Partnership has adopted. Much more will need to be done in actual implementation in affected countries, including those not considered high burden countries, if the targets are to be met on time. A report outlining progress, identifying constraints and making recommendations is currently with the Coordinating Board.

Changes in donor funding priorities and the establishment of new financing mechanisms such as the Global Fund to fight AIDS, TB and Malaria have intensified competition for limited resources and increased uncertainty over funding flows for the Partnership. The Partnership has recognised that advocacy and resource mobilisation needs to be handled more effectively, with the establishment of a proto Resource Mobilisation Task Force and new capacity in the Secretariat. Even so, the aim of secured long term financing of \$20-\$30m per annum starting from 2004 to sustain the Global Drug Facility in its present form does not appear realistic in current circumstances and alternative options are needed.

In general, global health partnerships raise sensitive institutional issues, balancing the need for inclusiveness and loosely-knit structures with a necessary minimum of business-like approaches and oversight. The tension has become more apparent in the Stop TB Partnership as the initial enthusiasm and compromises of start-up have given way to the

accountability demands of sustainable operations commanding substantial resources. Two recurring themes in evaluation interviews have been the need for the Partnership to become more business-like and to operate with greater transparency and openness.

In line with the Terms of Reference, the prime focus of this evaluation has been on the optimal structure and function of the Partnership, with detailed recommendations for improvements in governance, Partnership and secretariat structure, workplanning, financial management, human resource management and transparency in the conduct of Partnership business and information flow.

Other Key Findings and Recommendations

Institutional Issues

- The broad building blocks of the Partnership architecture are appropriate. There is support for the concept of a Partners' Forum and a Coordinating Board, and for a focus of activities on DOTS expansion, DOTS-Plus for MDR TB, TB and HIV/AIDS, new diagnostics, new drugs and new vaccines plus the cross-cutting issues of resource mobilization and advocacy and communications, as being the key elements to stop TB both now and in the longer-term.

The Board

- The Coordinating Board should address in plenary the extent to which the Board has a steering and/or coordinating function among Partnership constituencies and components. The evaluation team recommends that the Board should "guide and provide oversight of the implementation of agreed policies, plans and activities of the Partnership; and ensure coordination among partnership components". The relationship between the Partners' Forum and the Board should be more explicitly defined, with strategic and operational decision-making resting with the Board.
- The current composition of the Board in the Basic Framework should be amended to accommodate representation from people with TB or TB/HIV, the corporate sector, the foundations separately from financial donors, and the GFATM formally. To avoid increasing an already sizeable Board, the number of seats for regional representatives should be reduced from six to three, rotating through all six regions.
- Processes to select Board members should be timely, transparent, fair and open, with explicit selection criteria. Before each round of rotations, the Board should agree the ideal balance of diversity and expertise being sought, including broader skills in, for example, advocacy or financial management.
- With the transition to sustainable operations, the Board should strengthen its oversight mechanisms, streamline consideration of issues through pre-processing by Board members, and delegate some authority for routine decision-making within agreed limits. An Executive Committee of the Board with defined delegated authority for decision-making should be established, composed of seven Board members including a Chair elected by the Board. The current Working Committee would be dissolved.
- If the Board accepts the recommendation for an Executive Committee, an ad hoc Board Task Force should develop proposals for the extent of authority to be delegated to the Executive Committee and/or Executive Secretary, to be considered at the Board's meeting in Spring 2004. It is critical that Board members have ownership of this process.
- The Board needs to address more aggressively its substantive function to mobilise adequate resources for the various activities of the Stop TB Partnership.

Working Groups and Task Forces

- Core Partnership activities requiring active and continuing Board engagement and oversight should be eligible to be Working Groups, regardless of whether their functions

are cross-cutting. Task Forces should be used for ad hoc tasks or activities which do not require direct and continuous Board engagement, and report to the Board.

- Both Working Groups and Task Forces should be limited to the term of each 5-year Global Plan with an automatic sun-setting clause, subject to review of relevance and efficacy for the next Plan.
- A comprehensive and cohesive vision of how the various Working Group streams of activity come together is urgently required. The evaluation endorses recommendations from a Secretariat project, in particular that the potential contributions of new tools and approaches should be incorporated into descriptions of overall strategies to meet global targets and that progress towards reaching targets for development of new tools should be included in annual Partnership reports. There should be an annual meeting of the Chairs and focal points of all six Working Groups.
- Information, communication and advocacy are central to the activities of the Partnership from the global to the community level. They merit a higher profile and more effective handling within the Partnership. The Advocacy and Communications Task Force should be reconstituted as a formal Working Group, with a seat on the Board for its Chair to ensure the availability in Board discussions of appropriate expertise in this area. It should develop a detailed plan for advocacy and communications, including identifying areas of potential collaboration with global partners with expertise in this area.
- Advocacy by the Partnership should include advocacy for research activities, from basic research to operations research. The Board should ensure some contribution to the cost of New Tools Working Groups' partnership activities through the budget of the Partnership Secretariat.

The Secretariat

- Board members look to the Secretariat to play an activist role in shaping strategies, securing consensus and implementing initiatives. Secretariat functions should incorporate a greater emphasis on resource mobilisation, advocacy and communications, and on accountability mechanisms. Scope for greater delegation of formal authority to the Executive Secretary should be considered by the Board in the context of considering delegation of authority to an Executive Committee.
- The location of the Secretariat in WHO benefits both parties, despite the administrative frustrations encountered. Technical relationships are strong, without compromising the Partnership's independence. WHO has played a relatively hands-off and constructive role in governance. WHO's Programme Support Charge broadly offsets indirect costs incurred in hosting the Secretariat and WHO makes a substantial net contribution to the Partnership. Outstanding legal and administrative difficulties now need to be resolved, and the agreement formalised in an MOU between the Partnership and WHO.
- Ideally the Executive Secretary of the Stop TB Partnership should report to the Chair of the Partnership's Coordinating Board (as representative of the whole Board). However, on current WHO advice, so long as the Executive Secretary is a WHO employee, s/he must report formally to the WHO Director of Stop TB, though under the guidance of the Stop TB Coordinating Board. This position should be reconsidered if a different outcome is adopted in relation to the Roll Back Malaria Executive Secretary.
- The innovative process used recently to appoint a new Stop TB Partnership Executive Secretary could be a model for other Partnerships housed in WHO. There should be an early review of the grading of the post of Stop TB Partnership Executive Secretary, with a view to upgrading to D1 as a minimum.
- Staff in the Secretariat are deeply committed to the mission to Stop TB. After a difficult period involving loss of key staff and serious funding challenges, the Secretariat urgently needs clear and effective leadership, a more strategic approach, stronger management and decision-taking, and better internal communications. These are key issues to be addressed by the new Executive Secretary, in close cooperation with the Board.

- The summary picture of Secretariat human resources is that staff numbers may be a little too high, grades too low, contracts too uncertain and turnover too rapid. A comprehensive human resources strategy for the Secretariat should be developed as a matter of urgency, in concert with WHO's HRS and the MSU. The Secretariat is relatively strong on technical TB skills but there is need to develop a more managerial culture and strengthen expertise in advocacy and communications, resource mobilisation and planning/performance management.
- To free more of the Executive Secretary's attention for his external functions, he should be supported by a strong management structure, including a new senior Finance and Administration Officer position to ensure the effective management of financial and human resources across the Secretariat (including the GDF).
- The Stop TB Partnership and its MSU need to work together, on the model of the polio eradication initiative, to find ways to reduce delays and agree flexibilities for core Secretariat staff, within the context of a Secretariat human resources strategy. WHO should take urgent steps to reduce the unjustifiable delay in processing fixed-term recruitments not just for the Partnership Secretariat but for the whole of HQ.

Partnership Processes

- There should be clear and transparent processes, agreed ahead of time and easily accessible, for all routine matters of due process. Processes for the appointment of the Board Chair and Vice-Chair should be agreed and publicised. The Basic Framework should be amended to make explicit that each of the recognised constituencies may raise issues for consideration by the Board, either through the Secretariat or through their representative on the Board. To the maximum extent possible, the decisions of the Board should be taken by consensus but the Board should agree a voting process as a fallback.
- Coordinating Board papers and reports should be accessible to partners and the general public, except for exceptional confidential issues, e.g. relating to commercial/contractual or personnel issues. All substantive partnership meetings and teleconferences should be fully documented and the notes made available.
- There is scope for improving performance and financial management and reporting. The Secretariat should provide a brief written progress report on past Board decisions for each Board meeting.
- Current budget processes lack credibility. More realistic and flexible approaches to planning are recommended in the evaluation report. The next Global Plan should set out best estimates of projected financial needs but introduce a rolling annual budgeting process. Alongside a fund-raising budget, the Board should approve a realistic operational control budget for the Secretariat (including the GDF) to provide the basis for activity implementation and for expenditure monitoring and accountability.
- The Secretariat should produce a common performance management report for the Board, all donors and the public. This should provide information on expenditures and trends in progress against an agreed set of performance indicators over time against targets. The Board should receive a specific summary report on the GDF, and a more detailed GDF monitoring report for internal management purposes should be introduced.
- The Board should develop a formal results-based management approach to monitoring progress against the Global Plan, with a mid-term review and end evaluation for each five-year cycle. In particular, it should seek the agreement of the Working Groups to annual financial and activity reporting on the understanding that the reports will be used effectively to assess collective progress towards targets.
- The Partnership should contract out a survey of global flows of funding for TB to feed into the next Global Plan.

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ABBREVIATIONS

AMS	WHO Activity Management System
ART	Anti-retroviral therapy
ATS	American Thoracic Society
CCM	Country Coordinating Mechanism
CDC	Centre for Disease Control and Prevention
CIDA	Canadian International Development Agency
DOTS	Directly-Observed Treatment (Short course)
fte	Secretariat staff full-time equivalent
GAVI	Global Alliance for Vaccines and Immunization
GDF	Global TB Drug Facility
GFATM	Global Fund to fight AIDS, TB and Malaria
GLC	Green Light Committee
HBC	(TB) High Burden Country
HRS	WHO Human Resource Services
IUATLD	International Union Against Tuberculosis and Lung Disease (UNION)
KNCV	Royal Netherlands Tuberculosis Association
MDG	Millennium Development Goal
MDR-TB	Multi-drug resistant TB
MoU	Memorandum of Understanding
MSH	Management Sciences for Health
MSU	Management Services Unit, WHO
NGO	Non-governmental organisation
NICC	National Inter-agency Coordinating Committee
PSC	WHO's Programme Support Charge
RBM	Roll Back Malaria
STBP	Stop TB Partnership
SWAp	Sector-wide Approach
TB	Tuberculosis
TRC	GDF's Technical Review Committee
TRP	GFATM's Technical Review Panel
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV / AIDS
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WHA	World Health Assembly

I: THE GLOBAL STOP TB PARTNERSHIP AND THE APPROACH TO THE EVALUATION

The Global Partnership to Stop TB

1. Tuberculosis (TB) is one of the leading causes of infectious deaths worldwide. Despite a proven and affordable strategy to control it in DOTS, TB kills almost 2 million people every year. Many of them are young adults who should be in their most productive years. TB is a disease of poverty that traps the world's poorest, most marginalized and most vulnerable in a cycle of disease and impoverishment. It disrupts the social fabric of society through the stigmatisation of sufferers, and its impact on the family is profound, especially if the sufferer is the principal wage-earner¹. Some parts of the world are now facing multi-drug resistant TB. TB is also a leading cause of death among HIV-positive people.

Key events in the establishment of the Global Stop TB Partnership

1991: WHA resolution set TB control targets for 2000; targets later postponed to 2005.
1993: WHO declared TB a global health emergency.
1996: TB Diagnostics Initiative created.
1998: Report of the Ad Hoc Committee on the TB Epidemic.
Stop TB Initiative for Global Action campaign launched.
1999: Working Group on DOTS-Plus for MDR TB set up;
Green Light Committee established as its subgroup in 2000.
March 2000: Ministerial Conference on TB and Sustainable Development (20 countries), leading to the Amsterdam Declaration to Stop TB
2000: Global Alliance for TB Drug Development established.
1st meeting of DOTS Expansion Working Group.
Feb 2001: Stop TB (Interim) Coordinating Board meeting, Bellagio.
2001: Global TB Drug Facility (GDF) established.
2001: TB-HIV Working Group established.
Global TB Vaccine Forum established.
2001: Global DOTS Expansion Plan
October 2001: 1st Stop TB Partners' Forum, leading to the Washington Commitment.
October 2001: Launch of the *Global Plan to Stop TB, Phase 1 2001-2005*
28-29 October 2001: 1st Global Stop TB Partnership Coordinating Board
2001: GFATM launched, including TB

2. In 1991 the World Health Assembly set targets for TB control by 2000. However, it was clear by 1997 that most countries with a high burden of TB would not reach the targets. The following year an influential report by an Ad Hoc Committee on the TB Epidemic² concluded that weak political will and commitment was one major constraint and called for a Global Charter on TB. The Charter was to be an agreement between international agencies like WHO, the World Bank and donors on the one hand and the governments of endemic countries on the other, about specific steps to be taken to control the TB epidemic to a given timescale. As an adjunct to the Charter, it also recommended the establishment of a Global Drug Facility for the procurement and distribution of anti-TB drugs.

¹ WHO/Stop TB Partnership *Towards a TB-free Future*, WHO/CDS/STB/2001.13

² Global TB programme, WHO, *Report of the Ad Hoc Committee on the Tuberculosis Epidemic, London 17-19 March 1998*, WHO/TB/98.245

3. In 2000, a milestone conference on Tuberculosis and Sustainable Development brought together Ministers from 20 of the 22 countries that account for 80% of the world's TB burden, and high-level representatives of UN agencies, technical agencies and donor countries. The resulting Amsterdam Declaration set time-bound targets to stop TB. The first official Global Stop TB Partners' Forum and the first meeting of the Global Stop TB Partnership Coordinating Board were held in 2001.

4. There is no consensus about what constitutes the precise start of the Global Stop TB Partnership. It seems a matter of continuous creation rather than Big Bang, with seminal moments in 1998, 2000 and 2001. This evaluation focuses on events since the Amsterdam Declaration of March 2000. But it recognises the important foundation laid by earlier events and that the formal structures of the Partnership mostly came into effect in 2001. Formally, the Partnership is a young entity, currently undergoing the transition from start-up to sustainable operations.

5. At its simplest, the Global Partnership to Stop TB is a global movement to accelerate social and political action to stop the unnecessary spread of TB around the world. It is open to all those who demonstrably share that aim.

6. The partnership has a broad mission and specific targets³. To achieve them, it is focusing particularly on the 22 countries with a high burden of TB. A *Global Plan to Stop TB* developed in 2001 maps the projected work programme from 2001-2005 for the Partnership Working Groups and the Secretariat.

<p style="text-align: center;">Mission</p> <p><i>To increase access, security and support to:</i></p> <ul style="list-style-type: none">▪ <i>ensure that every TB patient has access to TB treatment and cure</i>▪ <i>stop transmission of TB</i>▪ <i>protect vulnerable populations from TB</i>▪ <i>reduce the social and economic toll that TB exerts on families, communities and nations.</i> <p style="text-align: center;">Targets</p> <ul style="list-style-type: none">▪ <i>By 2005: 70% of people with infectious TB will be diagnosed, and 85% cured.</i>▪ <i>By 2010: the global burden of TB disease (deaths and prevalence) will be reduced by 50% (compared with 2000 levels).</i>▪ <i>By 2050: the global incidence of TB disease will be less than 1 per million population.</i> <p style="text-align: center;">MDG TB-related Target and Indicators</p> <p><i>Target 8: By 2015, to have halted and begun to reverse the incidence of malaria and other major diseases.</i></p> <p><i>Indicator 23: prevalence and death rates associated with tuberculosis</i></p> <p><i>Indicator 24: proportion of tuberculosis cases detected and cured under directly observed treatment short course (DOTS)</i></p>
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The Evaluation of the Global Partnership to Stop TB

7. This independent external evaluation of the Global Partnership to Stop TB was commissioned by the Stop TB Partnership Secretariat at WHO, at the request of the Partnership's Coordinating Board. The aspects of the Partnership to be evaluated are its relevance, efficacy, efficiency, sustainability, institutional development impact, process, governance and implementation. A fundamental question is "does the Partnership add value to the global efforts to control TB over and above what would be accomplished without the Partnership?" However, the Terms of Reference (Annex A) make clear that "this is not a performance evaluation so much as an enquiry as to the optimal structure and function of the Partnership". There is therefore a particular focus on issues of structure and functions.

³ Stop TB Partnership website: www.stoptb.org

8. The evaluation fieldwork took place between August and October 2003, followed by draft report-writing by November 11. Details of the approach to the evaluation are given in Annex B. It involved interviews with nearly 100 people at global regional levels, fieldwork in six countries, a review of the literature and internal documentation, and attendance at meetings of Partnership bodies. An overview of the findings from the country visits is attached at Annex C; individual country visit reports are at Annex D. The evaluation team is hugely indebted to all those who contributed so much thought and time to the evaluation.

9. The evaluation took place against the background of an independent evaluation of the Partnership's Global Drug Facility (GDF) by McKinsey & Co. from January-March 2003 and simultaneously with a number of other activities of direct relevance, notably:

- an extensive review of implementing global TB control by the 2nd Ad Hoc Committee on the TB Epidemic, convened by the DOTS Expansion Working Group
- the establishment of the Trust Fund Task Force of the Board
- Dr Philip Hopewell's Secretariat project on Re-examining the Roles and Responsibilities of the Stop TB Working Groups
- a consultancy on resource mobilisation by Finlay Craig

10. Given the TOR's emphasis on avoiding duplication of efforts and capitalising on ongoing processes and findings, issues covered by these studies have not been re-examined in detail by this evaluation. The team has, however, included the GDF in a wider examination of Secretariat performance and financial management, and reviewed progress on the GDF since the McKinsey evaluation.

11. The Global Partnership to Stop TB is one of a large number of global health alliances which have been established in recent years. They are needed because no single player has the funding, research and delivery capabilities required to solve a global problem like TB. But a 2002 McKinsey study⁴ noted that they pose unique challenges: involvement of multiple partners from different institutions (and cultures), challenging and long-term objectives, needing to work effectively on an international basis and few guidelines as yet for setting up or managing such alliances.

12. The evaluation briefly reviewed the organisational features of three other bodies: the Global Alliance for Vaccines and Immunisation (GAVI), Roll Back Malaria (RBM) and the Global Fund to fight AIDS, TB and Malaria (GFATM). The chart below briefly summarises their key features. There are strong similarities between the Stop TB Partnership (STBP), GAVI and Roll Back Malaria.

- No legal identity for the partnership itself and being hosted in a UN agency – the Stop TB Partnership and RBM in WHO and GAVI in UNICEF
- A broad Partners' Forum, typically meeting every two years, plus a partnership Board for decision-making. The Stop TB Partnership and GAVI have a Working Committee/Group but with somewhat different natures. Stop TB also has six very active Working Groups. The longer-established GAVI has had four Task Forces but is currently winding up three.
- A Secretariat formally employed by the host agency. These tend to be relatively small on the basis that they should not in general be operational, and partnership activities should be mainstreamed to partners. Nonetheless, the Stop TB Partnership's Global Drug Facility is managed by the Secretariat. The Executive Secretary of the Stop TB Partnership reports up the WHO hierarchy, whereas the GAVI Executive Secretary reports to the Chair of the GAVI Board. As examined in detail in section V, the reporting lines of the RBM Executive Secretary are currently under discussion

⁴ *Developing successful Global Health Alliances*, McKinsey & Company, for the Bill and Melinda Gates Foundation, 2002

13. The Global Fund also has a Partners' Forum, decision-making Board and a limited number of committees. It is a legal non-profit foundation, employs its own staff and has a sizeable secretariat but uses some WHO administrative systems.

Organisational Features of Selected Global Partnerships

Feature	Global Partnership to Stop TB	GAVI	RBM Current /proposed by external Evaluation	GFATM
Status	Not a legal entity. Hosted by WHO.	Not a legal entity. Hosted by UNICEF.	Not a legal entity. Hosted by WHO.	Legal entity – non profit foundation registered in Switzerland
Partners' involvement	Partners' Forum (at least every two years)	Partners' Meeting (at least every 2 years)	Annual Partners' meeting /RBM Forum every 2 years	Partners' Forum (at least every 2 years)
Agreed operating plan	Global Plan to Stop TB 2001-2005, including 5-year plans for the Partnership's 6 Working Groups and for the Secretariat. GDF Strategic Plan 2002 to 2005	Strategic Framework 2004/5	WHO Cabinet Project: Composite Workplan (2000) which will be replaced by RBM Strategic Orientations 2004-2008 (currently under preparation)	Annual workplans based on the approved principles and priorities of the Board and the Global Fund Framework Document
Policy setting, decision making	27 member Coordinating Board.	16 member GAVI Board	Secretariat /RBM Partnership Board currently 17 members	18 member GFATM Board.
Partnership operations and implementation	Working Committee/ Secretariat. Technical Review Committee for advising on GDF proposals.	Working Group/Secretariat. A 7 member Executive Committee of the Board has recently been approved.	Secretariat	Technical Review Panel for proposals; Secretariat; partnerships with technical organization and an Administrative Service Agreement with WHO
Forging technical consensus among partners/ info sharing	Six working groups 3 Implementation Groups <ul style="list-style-type: none"> • DOTS expansion • HIV related TB • DOTS-PLUS FOR MDR TB, 3 new tools Groups: <ul style="list-style-type: none"> • diagnostics • drugs • vaccines 	Previously 4 Task Forces: R&D now ended; Advocacy and Communications and Implementation Task Forces (now winding down); Financing Task Force continuing.	Technical support networks /TSNs organised around RBM interventions	General: Four committees: (1) Governance and Partnership, (2) Resource Mobilization and Communications, (3) Portfolio Management and Procurement, and (4) Monitoring and Evaluation, Finance, and Audit.
Administration - nos. - prof/general - budget	Secretariat 34 staff in position (23 professional, 11 support staff. Secretariat expenditure (excluding GDF) of \$2.5m in 2001, \$5.05m in 2002. Country level commitments of \$57.4m.	Secretariat of 12 (8 professional and 4 general staff) plus currently 4 short term staff. Secretariat budget of \$3.9m for 2003. Country level commitments of \$1.03bn over 5 years	Secretariat currently 11 professional staff at HQ and 6 support staff. In addition there will be 4 sub regional focal point and a regional focal point positions (yet to be recruited). 2004/5 Work plan of \$23.5m, of which 25% is HQ based.	Secretariat 74 staff (58 permanent / 16 interim). Secretariat staff budget of \$38.7m for 2003, \$16 m of which is for in-country Local Fund Agents to oversee those entities in charge of grant implementation (PRs). \$922m committed over 5 years during Rounds 1 and 2; \$130m disbursed to date.
Executive Head - reporting lines - authority	P6. Reports to WHO Director, ADG and DG.	D2. Reports to Chairperson of the GAVI Board	Post advertised Oct 2003 as D2 (possibly D1), reporting functionally to RBM Partnership Board, but administratively to WHO Director. Actual grade and reporting line currently under discussion.	Reports to GFATM Board
Responsibility for fund-raising	Board and Secretariat	The Vaccine Fund (independent legal entity)	Secretariat (Secretariat)	Chairman of Board/Secretariat
Financial management arrangements	Through i) WHO and ii) Trust Fund established at World Bank in Nov 2002.	Through Vaccine Fund and Trust Fund Account in UNICEF	Through WHO	World Bank acts as Trustee
Performance management reporting	Reports to Coordinating Board.	Reports to GAVI Board.	Reports to RBM Partnership Board	Reports to GFATM Board
Technical support to countries	DOTS Expansion; DOTS-Plus for MDR TB; TB/HIV Working Groups.	Regional Working Groups	RBM Secretariat/WHO/Regional Offices/TSN	None – through cooperating partners UNAIDS, Stop TB, RBM
Country level catalyst	Interagency Coordinating Committee	Interagency Coordinating Committee	National Malaria Programme Officers appointed by WHO (RBM champion appointed by Secretariat)	Country Coordination Mechanism
Focus countries	Yes: primary focus on 22 high burden countries, but Global Drug Facility serving wider needs.	General eligibility criteria (<\$1000 per capita). Enhanced efforts to be made in 7 large population countries according to the Strategic framework.	No (focus on 8-12 countries)	Yes: Priority to technically and developmentally sound applications from countries and regions with the greatest need and greatest lack of resources, and countries facing risk of increased disease burden.

II: RELEVANCE, EFFICACY, EFFICIENCY AND SUSTAINABILITY

14. This section evaluates the relevance, efficacy, efficiency and sustainability of the Partnership.

Relevance

15. WHO has estimated that worldwide in 2000 there were 8.2 million new cases of tuberculosis and 1.82 million deaths from TB, of which 226,000 (12%) were attributable to HIV⁵. The global incidence rate of TB is growing at approximately 0.4% per year, with much faster increases in sub-Saharan Africa and in countries of the former Soviet Union. Multi-drug resistant TB (MDR-TB) is a serious threat, with a high prevalence in specific regions.

16. The strategic objectives of the Partnership to achieve its mission and targets are clear and well defined:

- expanding DOTS coverage
- adapting DOTS to address the challenges of HIV-TB co-infection and multi-drug resistant TB
- accelerating the development of new and improved TB drugs, vaccines and diagnostics
- broadening the Partnership.

17. The strategic objectives of the Global Plan to Stop TB were formulated specifically to address the main constraints to effective TB control identified in 1998 by the 1st Ad Hoc Committee on the TB Epidemic in close consultation with high burden countries themselves. TB remains a global emergency in 2003, and there is widespread consensus that the strategies remain relevant and appropriate.

18. TB is now on the global development agenda. For example, two out of the 48 indicators for the United Nations Millennium Development Goals (MDGs) relate to prevalence and death rates associated with TB, and the percentage of TB cases detected and cured using DOTS (directly observed treatment, short course). The Millennium Development Project has a sub-group of Task Force Five specifically dedicated to TB. One of the proposals of the July 2000 G8 Okinawa Summit was to reduce TB deaths and prevalence by 50% by 2010.

19. The mission and objectives of the Partnership are therefore highly relevant and specifically directed towards the intended problems and policy priorities of the principal stakeholders. Overall, the relevance of the Partnership and its objectives should be rated high.

Efficacy

Progress

20. The Partnership has set itself precise, measurable, time bound targets as given in section I. The most immediate are to achieve World Health Assembly targets of i) detecting 70% of smear-positive cases and ii) successfully treating 85% of all such cases by 2005.

21. The Partnership has a process of review and strategy modification demonstrably in place. Over the last few months, the 2nd Ad Hoc Committee on the TB Epidemic convened by the DOTS Expansion Working Group has undertaken an extensive and consultative review of progress achieved so far and identified the main constraints to achieving the global targets.

⁵ Corbett E, Watt C, Walker N, Maher D, Williams B, Raviglione M, Dye C. The growing burden of tuberculosis: global trends and interactions with the HIV epidemic. *Arch int Med* 2003; 163: 1009-1021

2nd Ad Hoc Committee Balance Sheet on Progress

Positive

- Increased funding flows for TB control, eg through the GFATM
- A series of implementation steps internationally (eg flow of anti-TB drugs through the GDF) and in many countries (eg expanded implementation of the DOTS strategy and improved case detection)
- A decrease in the estimated TB incidence rate from 1997-2000 in the American (-4.1%), Eastern Mediterranean (-1.4%) and South-East Asian (-1.3%) regions.

Negative

- Insufficient international commitment to, and planning for, actions beyond the current scope of the main stakeholders in TB control
- A funding gap for TB control, largely representing the funding necessary to strengthen the general health service infrastructure and to provide high-quality technical support to countries
- Inadequate achievement of progress towards the 2005 targets globally for case detection and in particular regions for treatment success (72% in Africa and 77% in Europe)
- An increase in the estimated TB incidence rate from 1997-2000 in the African (4.3%) and European (2.8%) regions, with no change in the Western Pacific region.

22. Amongst the major constraints identified for action are: inadequate information, communications, advocacy and social mobilization; a looming financing crisis facing the Global Drug Facility; the need to broaden the partnership to include more NGOs, the corporate sector, public/private partnerships at country level; broader health systems issues including primary health care, stewardship functions, and health in the context of poverty reduction; the health workforce crisis; response to the HIV/AIDS emergency; and investment in research and development to shape the future.

23. The Committee's findings and recommendations⁶ for the strategic direction for the Stop TB Partnership over the next five years were submitted to the Partnership Coordinating Board in October 2003, and are to be discussed at the next Partners' Forum. The Report on the Meeting of the Second Ad Hoc Committee on the TB Epidemic: Recommendation to Stop TB Partners is available in Annex P.

Added value issues

24. The key evaluation question posed by the Terms of Reference is "Does the Partnership add value to the global efforts to control tuberculosis over and above what would be accomplished without the partnership?"

25. The identification of "added value" in global health partnerships can be relatively nebulous. The partnership has defined three closely inter-related areas where the partnership will accomplish more than would be possible for partners individually:

- information and communication
- investment mechanisms, including information on resource flows for TB and identifying funding gaps and priorities
- coordination and mobilisation (of partners)

26. There are - unsurprisingly - strong analogies here with the principles of its added value that GAVI has identified as the basis for defining its priorities:

- coordination and consensus-building
- funding support to countries (from The Vaccine Fund) to purchase vaccines and support the operational costs of immunization
- innovation in processes and actions
- advocacy and communications

⁶ Report of the 2nd Ad Hoc Committee on the TB epidemic. *Implementing global TB control: solutions to DOTS expansion constraints DRAFT 2003*

27. The Stop TB Partnership has also defined a specific set of values:

- urgency
- equity
- shared responsibility
- inclusiveness
- consensus
- sustainability
- dynamism

28. While these are likely to be the right added value areas and under-pinning values, the Stop TB Partnership does not appear to have in place specific indicators or mechanisms for monitoring them. It is recommended that the next Partnership Global Plan should include such indicators. It will be helpful for the Partnership to have some broader measures of the health of the Partnership⁷.

29. In circumstances where many players were already contributing to action against TB before 2000, the difficulty of assessing what achievements since then are directly attributable to the Partnership is widely recognised. Without exception, interviewees during the evaluation have taken the view that the Partnership does add value over and above what the partners could or would do individually. Interviewees commonly identify three key achievements of the Partnership to date:

- the Partnership itself
- the Global Plan to Stop TB
- the Global Drug Facility and Green Light Committee in increasing the availability, affordability and quality of first and second-line TB drugs

30. Intensive Partnership work on new tools – new diagnostics, new drugs and new vaccines – is also recognised as having a critical contribution to make to the campaign to combat TB but is inevitably working on longer timescales.

Added value from the Partnership itself

31. Membership of the Partnership grew quickly and substantially from 75 in 2000 to 210 in 2001 and currently stands at around 280 organisational partners.

Classification of Stop TB Partners	Total
Non-governmental organisations	139
Governmental organisations	69
Intergovernmental organisations	11
Academic institution	31
For profit organisation	9
Others	19
Total	278

Source: Stop TB Secretariat, December 2003

32. Over 3,000 individuals are on the Stop TB mailing list.

33. The level of interest and commitment of the Partnership's core members remains strong and is still growing. The demonstrable good will of members has contributed greatly to achieving consensus and avoiding major conflict in such a broad and loosely-knit entity. While it is arguable that some recorded achievements might have been secured without the Partnership, there is overwhelming agreement that they would have taken considerably longer.

⁷ A partnership assessment tool developed for the UK Deputy Prime Minister's Office measures partnerships against six principles: see Brian Hardy, Bob Hudson and Eileen Waddington, *Assessing Strategic Partnership: The Partnership Assessment Tool*, Strategic Partnering Taskforce, Office of Deputy Prime Minister, UK, 2003 (see Annex I)

34. The Stop TB Partnership has achieved a substantial level of success in heightening concern and political commitment at both the global and national levels by generating an awareness of the magnitude of the TB epidemic and the gravity of its impact on life and human suffering. Above all, it has succeeded in raising the profile and global response to the TB epidemic in high-level political forums such as the United Nations General Assembly (MDGs), the World Health Assembly resolutions, the G8 (Okinawa Summit), and regional institutions such as the Organization of African Unity (OAU - now the African Union). Many of the partners interviewed indicated that the commitments to action against TB from these forums have provided an enabling environment both for coherent fulfilment of policy objectives, and for significant gains in capacity on TB within their respective agencies.

35. The Stop TB Partnership has also been instrumental not only in championing the inclusion of TB in the GFATM, but also in bringing about significant increases in support from the funding partners e.g. USAID, CIDA, Netherlands.

36. The Partnership has built and is sustaining an effective umbrella network that has brought diverse groups together under a common vision. In a short time, the Partnership has galvanised a broad alliance between national governments, bilateral and multilateral funding agencies, humanitarian foundations, national and international NGOs, private/public partnerships around a common agenda and strategy for action in the Global Plan to Stop TB, 2001-2005.

37. This common platform is evident not only at the global level, but also at the regional and country levels, albeit with less intensity. There is a widespread perception that such a broad consensus could not have been achieved in so short a time by any one partner alone.

38. The close involvement of the high TB burden countries that was initiated at the Amsterdam Ministerial Conference and continued through their inclusion in the various components of the Partnership has not only fostered buy-in to, and ownership of, the Global Plan to Stop TB, but has increasingly placed primary responsibility for TB control in the hands of the affected countries. This is seen by many as an essential prerequisite for long-term sustainability. As the ultimate goal is the elimination of TB, building strategies and structures that will last must remain an underlying philosophy of the Partnership.

39. Findings from the six country visits (which may not reflect general experience) and consultations with regional and other country advisers, suggest that:

- The Global Stop TB Partnership is making significant progress (subject to data limitations) even in difficult environments, but there is still some way to go. In most countries visited, the last two to three years have seen:
 - much greater acceptance of the Stop TB Initiative and the DOTS Strategy
 - substantial improvement in attention to TB, and consensus on the way forward
 - policies, drug regimens and advocacy more in line with the DOTS strategy
 - the development of medium term plans for TB control supported by in-country technical assistance and NGO activities
 - better coordination among all partners through the use of Interagency-Country Coordinating Committees, Consultative Forums and Technical Meetings
 - increased national and international funding, training activities, IEC activities, and attention being paid to laboratory services, drug quality programme case finding and outcome information
 - some evidence of improved DOTS coverage and success rates (though still short of 2005 targets)

- The Global Partnership has added value at the country level and provided tangible benefits, eg through the GDF) technical support (through visits, meetings and training events) and advocacy work from partnership members, which have helped build up the visibility of the programme. Peer interaction at Ministerial and senior government official level has been very important and should continue to be encouraged.
- The facilitation of national participation in global meetings and information exchange is seen as a major benefit. Appreciation was expressed for the excellent technical guidelines and IEC documents produced by the Stop TB Partnership Working Groups.
- The focus to date has mainly been on developing partnerships at national level. In future, the emphasis will need to shift towards regional and sub-national levels and to supporting operational activities. Decentralisation will make this increasingly important. Promoting ownership of the TB programme down to health unit level is a key task for the next three years, by developing directories of country partners and stakeholders, improving data collection and reporting, and training in partnership building where required as outlined in the draft StopTB/WHO document: The Power of Partnership.
- While the Global Stop TB Partnership as a brand has generally achieved recognition within the TB fraternity at national level, there is little evidence of this spreading to national and political leadership, let alone to state/provincial, district or community levels. Lack of clarity and distinction between the Global Stop TB Partnership and WHO's Stop TB Department was common, even among those directly involved.
- Consideration of programme sustainability as outlined in the report of the 2nd Ad Hoc Committee on the TB Epidemic should be part of all programme evaluations.
- Much closer collaboration with HIV/AIDS programmes is required. In some countries this also applies to Leprosy and poverty reduction programmes.
- Advocacy efforts at country level should be markedly strengthened.
- The ongoing place of World TB Day in global advocacy needs to be evaluated.
- Partner funding should, where possible, be via direct budget support.
- Partners should find ways to simplify and streamline report writing by country staff.
- Data quality was reported as a serious issue in most countries visited. The Global Stop TB Partnership was seen as a potential catalyst to support improvements in this area.

40. An overview of country and regional findings is at Annex C and six summary reports of the country visits at Annex D.

41. Internationally, significant progress has been made in engaging the corporate sector in the fight against TB. Proctor & Gamble have provided specialist support, Eli Lilly has contributed in the area of MTR TB and technology transfer, the GDF is discussing drug donation with Novartis, and the World Economic Forum through its Global Health Initiative is working closely with the partnership in developing strategies for wider involvement of the corporate sector. A notable success in this regard has been the production of Guidelines for Workplace TB Control in concert with WHO and ILO. These relationships now need to be expanded, and institutionalised in the Coordinating Board and Working Groups.

42. At country level there have been only modest gains in recruiting the private for profit and non-formal health sectors into the national TB control programmes, even in countries such as India where they are major TB service providers. This is an area for intensified action.

The Global Plan 2001-2005

43. One substantial achievement is the Global Plan to Stop TB 2001-2005 which described the state of the TB epidemic and provided plans for the actions and investments needed with the aim of both accelerating efforts and increasing investments. Its objectives are to expand the DOTS strategy and adapt it to meet the emerging challenges of TB drug resistance and HIV; improve existing tools by developing new diagnostics, drugs and a vaccine; and strengthen the Global Partnership itself. Its widespread, if not yet universal, adoption is directing focussed and orchestrated action to ensure appropriate and modern TB treatment at all levels of national health systems.

44. Significant effort and success in facilitating effective country response through the creation of appropriate country coordinating mechanisms (NICC, CCM or similar) have contributed to reducing duplication and/or contradiction of effort, improving the efficiency of resource application and utilization, moving towards equity of access to TB control services, special targeting of the poor and most vulnerable, and a speedier rate of taking DOTS Expansion to scale in many countries. By 2002, 18 of the 22 high burden countries (HBCs) had NICCs or an appropriate equivalent.

45. The HBCs have been identified for high level political and technical advocacy and intensified support since the Amsterdam conference in 2000. In 2000, only nine countries had comprehensive national TB control plans but, by mid-2003, 155⁸ of the 210 eligible countries - including all but one of the 22 HBCs - had such plans and were implementing them. Many of the remaining countries are in various stages of developing one. Stop TB partners have played a major role in supporting the development of these national TB plans.

46. Nonetheless, as noted above, progress in reaching the global targets has been extremely mixed, with only 16 countries having achieved the global targets – accepting, of course, that countries began from a range of different starting points which has made the targets easier to achieve in some than others. Of these 16 countries, only two (Peru and Viet Nam) were high burden countries, though Peru's success means that it is no longer classified as a high burden country. While the global treatment success rate has risen to 82%, the rates for Africa and Europe are still only 72% and 77% respectively. Case detection remains low at only 36% globally, with 32% of all estimated sputum positive cases still being registered as of unknown outcome (Dye, WHO 2003). Much more will need to be done in actual implementation in the countries affected, including those not considered a global HBC, if the World Health Assembly targets are to be reached⁹.

47. Inadequate national capacity to develop and implement effective national TB control programmes has long been identified as a major constraint to achieving the national and global targets. The Partnership has established an expanding global support network that is harnessing expertise for national programmes. The Working Groups have developed and are disseminating various technical and management guidelines that have been reported by countries to be of excellent quality and appropriateness. By relying primarily on in-kind support of the partners at the various levels of the Partnership, a greater degree of continuity is assured and direct costs to both the national programmes and external partners are minimized.

⁸ Report of the 2nd Ad Hoc Committee on the TB epidemic. *Implementing global TB control: solutions to DOTS expansion constraints DRAFT 2003*

⁹ i) detecting 70% of smear-positive cases and ii) successfully treating 85% of all such cases by 2005

Increasing the availability, affordability and quality of TB drugs

48. Countries are being supported in developing proposals for support from the Global Drug Facility (GDF) and/or the Global Fund to fight AIDS, TB and Malaria (GFATM), and in accessing second-line TB drugs through the Partnership's Green Light Committee. The Green Light Committee is also the review body for the GFATM with regard to second-line TB drugs, and supplies the drugs to GFATM grantees using the GLC procurement agent.

49. The creation of the Global Drug Facility (GDF) featured very high on key informants' list of the achievements and added value of the Partnership. Participation in the GDF allows qualifying countries to benefit from a wide range of support services including drug grants, reimbursable / direct procurement services for TB drugs, capacity development in drug management, and surveillance and programme monitoring.

50. The report of a formal evaluation of the GDF undertaken earlier this year by McKinsey & Co. concludes that the GDF is well on its way to meet the objectives set on its establishment two years before, and that the Stop TB Partnership should continue to support it. Specifically, it finds that the GDF has demonstrated results in improving access to TB drugs in many countries. It has also had success, though to a lesser extent, in the second arm of its mission, indirectly to catalyse DOTS expansion. GDF could improve its effectiveness by strengthening advocacy, mobilization of partners and procurement practices. Furthermore, as GDF evolves from a start-up organization to a larger, more steady state form, key changes must be made to its organization to fill skill gaps, recruit more staff and formalize key management systems.

51. The GDF evaluation also finds that the GDF's unique bundled model comprising grant-making, procurement and partner mobilization for technical assistance is critical to its success. Maintaining GDF's direct grant-making role is necessary for continued impact. To do this, McKinsey estimated that the Stop TB Partnership must ensure funding of \$20-30 million per annum for each of the next three years and identified a serious funding gap to meet the GDF's 2003 commitments.

52. At the time of the evaluation's fieldwork, too little had been done to address the funding shortfall since the McKinsey findings were considered by the Board in early April 2003. The GDF's future is still seriously challenged by uncertainties about funding for the grant facility. This issue is discussed further under the section on *Sustainability* below.

53. Overall, the Partnership's contribution in its short life to stronger collaboration, shared planning approaches and a new facility of the order of the GDF merits a high rating for efficacy to date. But the real test will be delivery of the Partnership's own targets. Those for 2005 may not prove realistic.

Efficiency

54. The Partnership is promoting extremely cost-effective interventions: DOTS is internationally recognised as one of the most cost-effective ways of improving health. The 1993 World Development Report estimated that it cost \$1-3 per head for each healthy year of life saved¹⁰ through short-term chemotherapy compared to standard treatment and \$5-7 in middle income countries. Costs are likely to have increased somewhat since; HIV co-infection may have served to reduce health benefits; and expansion of the DOTS

¹⁰ Based on Murray CJ, DeJonghe E, Chum HJ, Nyangulu DS, Salomao A, Styblo K. Cost effectiveness of chemotherapy for pulmonary tuberculosis in three sub-Saharan African countries. *Lancet* 1991;338:1305-8.

programme towards harder to reach groups may have increased costs. Nevertheless, the basic finding on the cost-effectiveness of DOTS remains sound¹¹.

55. As a comparison, treatment of HIV/AIDS through anti retroviral therapy (ART) – also recognised as a key intervention in its own right and for its contribution to TB control, and a major beneficiary of Global Fund support – has been estimated more recently to cost between \$1,100 and \$1,800 per year of healthy life year saved¹². Even using extremely conservative assumptions, investment in DOTS results in at least ten times more health benefits achieved per dollar spent than ART. In addition, many of those benefiting from DOTS are from poorer income groups.

56. There have also been gains to efficiency of countries and partners' coordination under the umbrella of the DOTS Expansion Working Group and regional coordination efforts.

57. The direct costs of the Partnership Secretariat are relatively modest - US\$ 18.05m for the Secretariat in 2002, of which US\$13.0m was for the GDF.

58. The Secretariat claim that GDF procurement results in savings of the order of 30%. The available evidence tends to support this. Such savings¹³ (which are not considered to be the most important benefit of GDF) have in part offset the actual costs incurred by the Partnership¹⁴. Though a rather artificial comparison, this is nonetheless illustrative. On the same basis, if the GDF grant facility had been expanded in line with its Strategic Plan, or even its approved 2002 budget, all non- GDF Secretariat costs would have been offset.

59. The general conclusions are that the partnership does add value, that any value it does add will have large health benefits compared to the costs involved and also in comparison with other uses of funds and that in any case the "net" costs of the Partnership are low¹⁵. On these grounds, the evaluation rates the Partnership's overall efficiency rating as high.

Sustainability

Context and changes

60. The key contextual changes include:

- the transition from start-up (where there was acceptance of the need to make compromises to get the Partnership off the ground) to sustainable operations. While interviews suggest a felt need for more transparency, business-like procedures and effective decision-making, partners express continued strong commitment to the Partnership
- changes in funding priorities and the establishment of new financing mechanisms such as the GFATM which have intensified the competition for limited resources and increased uncertainty over funding flows for the Partnership

¹¹ In "Interventions to reduce tuberculosis mortality and transmission in low- and middle-income countries" in the Bulletin of the World Health Organization 2002; 80:217-227. Borgdorff Floyd and Broekmans found that "Tuberculosis treatment could also be less than \$10 per DALY gained, but as high as \$68 when inpatient care was involved. DOTS is the most cost-effective at around US\$ 5-40 per disability-adjusted life year (DALY) gained. The cost for BCG immunization is likely to be under US\$ 50 per DALY gained. Treatment of smear-negative patients has a cost per DALY gained of up to US\$ 100 in low-income countries, and up to US\$ 400 in middle-income settings. Other interventions, such as preventive therapy for HIV-positive individuals, appear to be less cost-effective. Interventions to reduce tuberculosis mortality and transmission in low- and middle-income countries"

¹² See Creese 2002

¹³ The benefits (the savings) accrue to countries and result in greater provision than would otherwise be the case and hence directly benefit those suffering from TB. Figures presented here are based on a 30% reduction in drug prices as a result of GDF procurement.

¹⁴ For example in 2002 savings of 30% on the \$10.75m expenditure on drugs amounts to some \$3.22m, almost 2/3 of non-GDF Secretariat spending

¹⁵ Whilst the Secretariat attempts to capture the full formal costs of the Partnership including specific in-kind costs, it does not purport to capture the full costs (e.g. cost of donor Board attendance). The working assumption here would be that the partner considers that the benefits outweigh the costs involved

Sustainability of the Global Stop TB Partnership

61. The heart of the Partnership lies in the long-term commitment of individual partners of all kinds to work in concert to achieve the agreed goals. This is implicit in the Global Plan and in developing thinking to underpin a second phase Plan. Interviewees overwhelmingly made clear to the evaluation team their continuing deep-rooted support for the Partnership. While this is certainly sincere, it does need to be fully realised in terms of active participation (eg in the Partners' Forum) and resource mobilisation.

62. The establishment of the GFATM has also increased uncertainty over funding for the Partnership. Donors who might previously have provided direct support to the Stop TB Partnership are now increasingly channelling resources through the GFATM. While the GFATM has proved to be effective at mobilising support, it responds to country led proposals. This has resulted in a declining share of commitments to TB over successive funding rounds. It is also becoming increasingly clear that the GFATM itself is facing challenges in raising the funds needed to expand its programme of support.

Sustainability of TB Programmes at the country level

63. In terms of financial sustainability, national TB programmes are also facing increased competition for limited resources and greater uncertainty over future funding flows. In some cases this has led to reduced support for TB. The decision by the UK's Department for International Development to refocus their health programme in the Russia Federation away from TB towards HIV/AIDS is one example.

64. From a wider perspective, countries are receiving support through a number of global initiatives (Stop TB, GFATM, GAVI, Roll Back Malaria etc), all of which have significant recurrent implications. It is important therefore to view sustainability from an overall country perspective and improve collaboration between the various global initiatives to assess the affordability of the sum of their efforts.

65. More broadly, these global health initiatives rely on basic service delivery infrastructure responding to and absorbing the additional resources they bring. In its current draft strategic framework, GAVI recognises that it is neither feasible nor cost-effective to address system barriers (such as human resource constraints, physical infrastructure, monitoring, management and social mobilisation) through an isolated focus on immunisation-specific action. A similar view is expressed in the 2nd Ad Hoc Committee meeting report on the TB Epidemic which concludes that, for further progress in TB control, the TB community must reach out to the broader health improvement and poverty reduction community who must in turn support TB control as a contribution to achieve the MDGs.

Recommendation:

66. The Stop TB Partnership needs to play an active role in looking at the overall sustainability issues at country level raised by the various global health initiatives collectively, and in developing concerted contributions to country-based strategies for alleviating system-wide barriers to improved health services. Partnership advocacy efforts need to be targeted towards country level mechanisms, notably CCMs.

Sustainability of the Global Drug Facility

67. A key question about sustainability arises in relation to the Global Drug Facility (GDF), which is seen by many as a central jewel in the Partnership's crown.

68. The evaluation team's assessment is that the GDF appears to be developmentally sound but has been facing a serious short term financing problem as well as a longer term funding challenge in supporting DOTS expansion programmes. The underlying problem has been a

failure to raise resources to fund the grant facility in line with its Strategic Plan targets approved by the Board. This has been compounded by the Board's failure to respond in a timely manner to the shortfall against plan, either by intensifying resource mobilisation efforts or scaling down new commitments.

69. The precise position has been very much a moving picture during the evaluation. The recommendations below were framed at the end of fieldwork but attempt to reflect subsequent developments up to 25 November 2003.

70. The aim of secured long term financing of \$20-\$30m per annum starting from 2004 does not appear realistic in current circumstances. If this is right, alternative courses of action are needed. Any failure by the Partnership to honour its country commitments for drugs through the GDF is likely to have serious credibility implications for the Partnership as a whole and perhaps also more broadly within WHO and the wider international health system. The situation has not been helped by a lack of clarity with respect to the financial position and a failure to keep the Board adequately informed. This has resulted in a degree of confusion about when additional funds are required.

71. Recommendations:

- Broad approaches include:
 - ◇ improving the information base upon which decisions can be made
 - ◇ implementation of more realistic planning approaches, including a plan to address the current short to medium-term financial problems
 - ◇ actions to limit liabilities and maximise income with appropriate communications strategies.
- Immediate actions are also required. These include establishment of a regular reporting system which identifies (a) when obligations are likely to fall due and (b) if, or when, the Partnership might be unable to meet its GDF commitments.
- This analysis needs to spell out clearly when and how much additional funding is required, when new procurement contracts (or extensions of the existing one) will need to be signed and when orders need to be placed and deliveries made if stock outs at the country level are to be avoided.
- During the course of the evaluation, the Secretariat has prepared a revised financial statement which sets out the financing requirements to meet existing commitments – that is, without taking on additional commitments. In short, a total of \$1.5m is required by the end of 2003, a further \$11.6m in 2004 (\$5.8m, \$1.3m, \$1.5m and \$3.0m during quarters 1, 2, 3 and 4 of 2004) with some \$5.6m required during 2005. It is understood that CIDA has signalled its intention to cover these funding gaps and its wish for Technical Review Committees to be resumed. The financial report should be updated and recommendations put to the Board.
- The evaluation recommended to the Board in October 2003 that, as recommended by McKinsey, a Board Task Force (for example, the Donor Task Force or a new Resource Mobilisation Task Force being recommended by the resource mobilisation consultancy) should be charged to take immediate action to raise new resources to enable existing DOTS expansion commitments made through the GDF to be met. The Board has since established a Proto-Resource Mobilisation Task Force.
- This should be complemented by:

- a. a strengthened communications strategy, aimed at existing and potential donors, challenging misconceptions about access to GFATM resources, and outlining possible repercussions of a failure of the Partnership to fund its GDF commitments
 - b. board agreement that approval of new DOTS expansion projects under the GDF grant facility should not be considered unless there is a reasonable likelihood that the requisite funds can be secured¹⁶. This may require a significant scaling down of approvals. Any such action would require the development of a sensitive communication strategy to make this decision known to partner countries and to avoid unnecessary work on their part
- The GDF's Strategic Plan targets need to be reappraised and reflect more realistic assumptions about resource flows and other factors which may have changed since the Plan was approved. The draft 2004/5 Work plan proposed expenditure on drugs through the GDF grant facility of \$27.0m in 2004 and \$40.5m in 2005. During the course of the evaluation, the targets have been revised based on annual funding of \$15m per annum. This still implies funding levels well in excess of those achieved to date and further revision may be needed if such income is not forthcoming.
 - The evaluation recommended in October that funding principles or guidelines to prevent excessive exposure in the medium term and a financial plan to comply with such principles should be developed. An initial draft has been prepared by the Secretariat. Once agreed, it will be important to consider what implications these guidelines have for the size of future TRC approvals and to reflect this in communication strategies.
 - Future financial statements provided to the Board should include a detailed presentation of the medium term cash flow situation until the position has stabilised and should also monitor progress against any agreed principles or guidelines as set by the Board.

Broader Issues

72. The establishment of the GFATM as a key financing instrument to support TB has dramatically changed the environment in which the Partnership operates. One of the questions it raises is whether it is feasible or desirable for GDF to retain its grant-making facility or focus purely on the direct procurement route utilising funding from other sources (including the GFATM but also countries' own sources). The McKinsey report envisages a continued grant-making role though it does emphasise the need to "proactively plan" for a phase of initially grant support and later procurement support.

73. The problem the Partnership is facing is that funding for the grant facility has faltered, whilst little progress has been made in accessing alternative funding sources although there is some evidence of demand from countries wishing to use the direct procurement route from their own sources¹⁷.

74. In order to attract additional funding, the GDF will need to demonstrate continually the extent to which it adds value. The McKinsey report, monitoring reports and research findings need to be fully utilised to this end. In some areas, such as price, comparisons are fairly readily available and show that the GDF has been successful in the past in securing drugs at very competitive prices. In more important areas, such as the impact on treatment regimens

¹⁶ The September 2003 TRC meeting recommended approval of 11 out of 15 proposals valued at \$11.9m over 5 years. Some were new proposals, others were resubmissions and others were approvals for year 2 and 3 disbursements of already approved programmes which would be extremely difficult to reject if agreed conditions were met. In the light of proposed new CIDA funding, these recommendations have now been approved by the Executive Secretary.

¹⁷ Contracts have been agreed or are under negotiation in Nepal, Philippines, Morocco and Lagos State, Nigeria whilst Namibia and Mozambique have expressed interest. Additional support is being provided in Afghanistan, South Sudan, Armenia, Georgia and Iraq

and outcomes, data are more difficult to access and efforts should be made to build up a strong evidence base. Data on treatment outcomes will become increasingly available during 2004.

75. The future of grant support through the GDF has implications for the Partnership's financial relationship with WHO as the 6% Programme Support Cost (PSC) payments on drug purchases represents the majority of total WHO PSC revenue from the Partnership. To date, the costs incurred by WHO in hosting the Secretariat broadly balance PSC payments made to WHO. A significant change in the size of the grant support would have major implications for this balance. A decline in grant support would result in lower PSC and a net deficit for WHO in terms of its hosting role. This raises the question of whether Partnership means would be found to close the deficit or whether such a deficit would be recognised as a contribution by WHO to the Partnership.

Strengthening links with other related Global Initiatives

76. The Partnership should view the changing global environment and the massive momentum that has been generated for addressing the HIV/AIDS pandemic (particularly the Global Fund, the USA Presidential AIDS initiative and WHO's 3 by 5 initiative) as offering great potential for furthering the goals and objectives of Stop TB, rather than as creating competitors for available resources. The Secretariat, working closely with the Task Force on Resource Mobilization currently being contemplated by the Board, must define the challenges posed by these and similar initiatives with a view to designing effective strategies to maximize the benefits that Stop TB can derive from the increased resources.

77. The fears being expressed about the possible negative impact of "3 by 5" on already stretched NTPs must be translated into positive action through a proactive approach. This would include the speedy conclusion of strategies and guidelines as to how NTPs can effectively strengthen numbers and quality of national TB control personnel (both managers and service providers), and strengthen health infrastructure including laboratory backup services, supplies and data management.

The Partnership and the Global Fund

78. The relationship between the Partnership and the Global Fund has been subject to intensive discussion and activity within the Partnership Secretariat and Coordinating Board. High level discussion has also taken place among Coordinating Board members and the GFATM Secretariat. Grounds for collaboration are being further developed, including intensification of technical assistance from Stop TB Partners to GFATM grantees.

79. Links between the Partnership and the GFATM already exist:

- there is some overlap in Board membership on an individual basis. (Although UNAIDS is a member of the GFATM Board, Stop TB and RBM are not). The GFATM secretariat has been invited as an observer to Stop TB's Coordinating Board and Technical Review Committee (TRC) meetings, and this report recommends that the GFATM should have a formal seat on the Partnership Coordinating Board
- the Partnership's Green Light Committee acts as the mandated supplier to the GFATM of second line TB drugs
- all Coordinating Board decisions are reported to the GFATM secretariat
- the three GFATM Technical Review Panel (TRP) members for TB are members of the TRC of the GDF
- Global Fund portfolio managers are copied all GDF country and monitoring visit reports
- Global Stop TB partners participate in GFATM regional meetings, where invited

- Secretariat staff have met with GFATM portfolio managers to explain GDF mechanisms and sent them the direct procurement flyer
- there is cooperation in countries applying for GFATM funding as well as accessing GDF

80. A draft Memorandum of Understanding (MoU) between the Stop TB Partnership and the GFATM has been developed between the two secretariats¹⁸. This MoU was cleared by the Stop TB Coordinating Board just as the evaluation report was finalised. It will be submitted to the GFATM Governance Committee early in 2004 for clearance. If recommended, the MoU will be presented to the GFATM Board for endorsement at its next meeting.

81. It would not be helpful for the evaluation team to cut across these negotiations but the team would wish to offer some observations:

- Links between the GDF and the GFATM are unlikely to offer a solution to the short term financing problems faced by GDF under the grant facility. However, such links have a major bearing on the long term future of the GDF, especially the maintenance of its grant facility.
- The GDF should strengthen the empirical base on which it makes its arguments for accessing GFATM resources. A case in point would be early provision of evidence on the relative impact of different approaches (in terms of treatment regimens, quality of drugs, timeliness of delivery and price), especially in countries where funds are being disbursed through GDF as well as other channels (including GFATM).
- While it seems unlikely that the GFATM will make the GDF the preferred supplier of first-line TB drugs, it has signalled its intention to use “mechanisms which adopt and use a package of services such as that of the GDF”. The GFATM also sees “competent technical STBP members (for example, WHO, KNCV, IUATLD, CDC), (as) a premier source of technical support and advice on tuberculosis control to the Global Fund”. Although a second best option, such support could bring benefits even in the absence of a bundled approach. Given the growing demand for technical support, some partners are likely to require financial support to enable them to undertake this function.
- The Stop TB Partnership could give guidance to the LFAs on criteria for assessing procurement plans for TB drugs.
- Increasing the share of GFATM resources for TB is more likely to be achieved by actions at country level, aimed at CCMs, to push for inclusion of TB in GFATM proposals rather than trying to persuade GFATM to earmark specific amounts to TB. Notwithstanding this, relevant Board members might usefully try to hold the GFATM accountable to its principle of “operat(ing) in a balanced manner in terms of different regions, diseases and interventions” especially as the share of GFATM funds allocated to TB has declined during successive rounds.

¹⁸ Version November 12, 2003.

III: INSTITUTIONAL ISSUES: PARTNERS' FORUM and BOARD

82. As noted earlier, the Stop TB Partnership is one of a sizeable number of global health partnerships or alliances which have been established over the last few years. In terms of structure and governance, they tend to raise a set of sensitive institutional issues, balancing the need for inclusiveness and loosely-knit structures with a necessary minimum of business-like approaches and oversight. This is a tension which can become more apparent as the initial enthusiasm and compromises of start-up give way to the accountability demands of sustainable operations. The Stop TB partnership is at just that stage.

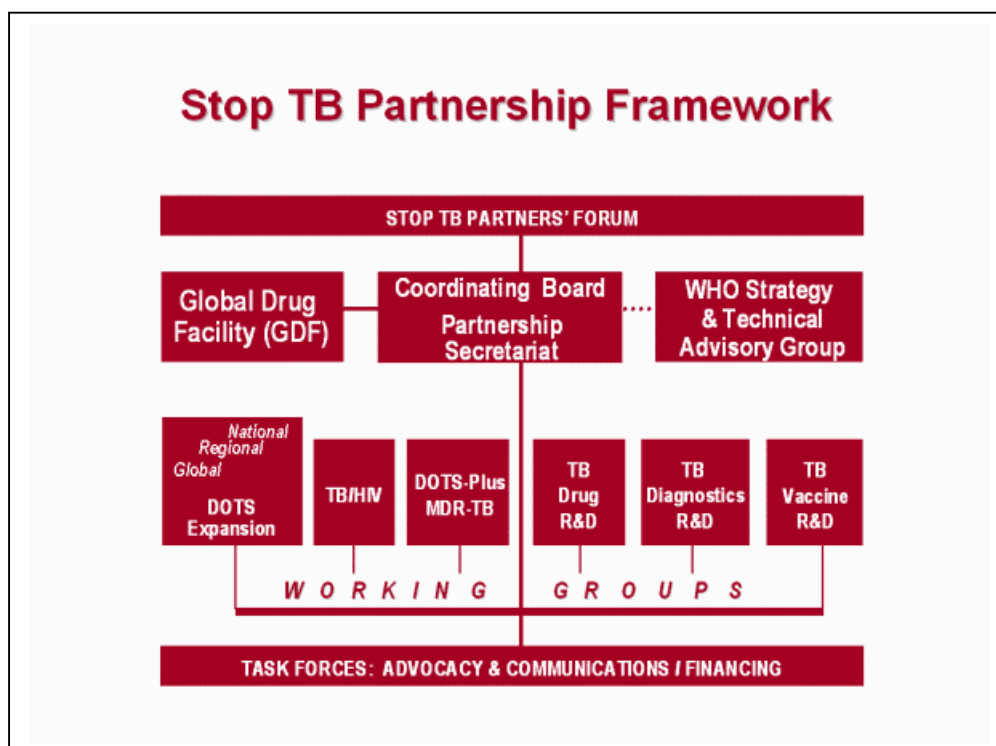
83. Key institutional elements in relation to the Stop TB Partnership are that it is not a legal entity, the decisions of the Board are not binding on its partner organisations and there appears to be a relatively high degree of autonomy between its component parts.

The Basic Framework

84. The formal institutional, operational and administrative arrangements for the Global Partnership to Stop TB are set out in its Basic Framework approved in 2001. It remains generally valid. Recommendations for a limited number of specific amendments are made in the course of this report.

Partnership Structure

85. The Partnership structure still reflects the decisions of an Ad Hoc Partners' Forum in 2000. The basic elements are a Partners' Forum, Coordinating Board linked to the WHO Scientific and Technical Advisory Committee on TB (STAG), Secretariat, Global Drug Facility (managed as part of the Secretariat) and six Working Groups. There is a Task Force on Advocacy and Communications but the original intention of a standing Financing Task Force was never operationalised as such. There have also been a number of ad hoc Task Forces.



86. There seems general agreement that these key building blocks of the Partnership architecture provide the foundation for a broad and durable alliance to stop TB. Interviewees continue to endorse the focus of activities on DOTS Expansion, MDR TB, TB and HIV/AIDS, new diagnostics, new drugs and new vaccines, plus the cross-cutting issues of advocacy and communications, as being the key elements to stop TB now and in the longer-term. However, these individual elements could and should be better articulated.

87. Generally there seems a helpful acceptance that the Working Groups should adapt or be absorbed, as progress is made. Structurally the allocation of advocacy and communications to a Task Force rather than a Working Group is a matter of current debate (see below).

The Partners' Forum

88. Like other major health partnerships such as GAVI, GFATM and Roll Back Malaria, the Stop TB Partnership has a Partners' Forum and a Partnership Board.

89. While the Stop TB Partners' Forum provides global review and recommendations, it delegates to the Board the detailed specific actions required to implement the mission of the Stop TB Partnership.

90. The Forum is an assembly of the partners, where a partner is defined as "either an individual or an entity (government/organisation) that declared with reason(s) and substantiation of the alignment of its goals and values with those from the Partnership and that has expressed interest to become part of the Partnership to Stop TB"¹⁹. The current exercise to update the partnership directory indicates about 280 partners. Attendance (as observers and upon invitation of the Executive Secretary) is open to all interested in the objectives of Partnership.

91. Under the Basic Framework, the Forum must meet at least once every two years.

Functions of the Partners' Forum

- *Identify problems and new challenges, and exchange information thereon.*
- *Consolidate and increase partners' commitment to the objectives of the Stop TB Partnership, and maintain and reinforce high-level political commitment to the Stop TB Partnership.*
- *Create and exploit opportunities for advocacy, communications activities, and social mobilization.*
- *Review overall progress towards implementation of the Stop TB Partnership, review reports presented by the Board, and make recommendations to the Board.*
- *Consider any other matter related to the Stop TB Partnership referred to it by the Chair of the Board or the Executive Secretary.*

92. The first official Stop TB Partners' Forum in 2001 reviewed progress since the Amsterdam Declaration, the Global Plan to Stop TB, and endorsed by consensus both the Basic Framework for the Partnership and the Washington Commitment. The Director General of WHO used the opportunity to sign the Memorandum of Understanding for the Global Drug Facility between the Partnership and WHO, its host agency. This summary encapsulates the value of the Forum – for broad and participatory consensus-building, partnership-wide endorsement of policies, strategies and plans, and high level global advocacy for TB.

93. A second Partners' Forum, originally scheduled for December 2003, will now take place in March 2003. It is intended to highlight progress at country level and the importance

¹⁹ *Principles for Selecting, Classifying and Accepting Partners*, Secretariat paper, Osaka Coordinating Board Meeting, February, 2002.

of private and civil sector involvement. There seem no grounds for the evaluation to propose amending the principles of the Forum after only one meeting, though these could be reviewed in the light of the 2004 meeting.

94. There is though need to assure:

- the participation of partners at the highest levels of governments, organisations and agencies, without which the value of any consensus reached and institutional commitment to implementation are unlikely to be realised
- a more effective operationalisation of the constituency concept envisaged in the Basic Framework. For example, with the notable exception of the Working Group Chairs, the evaluation found scant evidence of regular two-way communication between Board members and their constituencies. It should be noted though that there are likely to be limits to how far the development of the constituency can sensibly be taken. Serious attempts in the AMRO/PAHO region have proved unrewarding. GAVI has also found this a challenge

95. Recommendations

- In section V below, this report recommends a five-year cycle of planning, budgeting and reporting with a mid-term review of the Global Plan and an evaluation towards the end of the cycle to provide the platform for the next five-year Global Plan. Both the outcome of the mid-term review and the next cycle's draft Global Plan should be put to the Partners' Forum for endorsement, in line with practice to date. This suggests two Partners' Forum meetings in each five-year cycle. The Basic Framework should be amended to allow the Partners' Forum to meet at least once every three years rather than every two years.
- Each member of the Coordinating Board should take responsibility for mobilising participation in the Forum at the appropriate levels within their respective constituencies.
- The forthcoming Partners' Forum should be used to explore mechanisms for making the various constituencies more operational. As one example, the Stop TB Secretariat could support relevant constituencies in the design and operation of a constituency e-forum within the Partnership website, using the partners' directory as starting point. Constituencies should routinely seize opportunities offered by international meetings (UN, WHA, regional committee meetings e.g. of WHO, IUATLD, Partners Forum, etc) to engage their broader membership. Donor Board members could organise a more structured set of constituency relationships and communications, perhaps covering a number of global health partnerships not just Stop TB.
- A late session at the Partners' Forum in March 2004 could provide opportunity for participants to review the effectiveness of the gathering, lessons learned for the future and possible alternatives or additions, eg regional mini-partners' fora, piggybacking on WHO Regional Committee meetings.

The Coordinating Board

96. The evaluation found support for the concept of a Coordinating Board, though opinions varied widely on its role and functions, and in particular on the relationship between the Board and the Working Groups.

Functions

97. The Board represents and acts on behalf of the Partnership and provides oversight of the implementation of the Global Plan to Stop TB. As the Partnership is itself not a juridical entity, the Board has no legal authority.

Board Functions

- *Formulate priorities for action by the partnership in line with health policy and technical advice from WHO and in the light of the recommendations of the Forum*
- *Support the Partners according to agreed policy and strategy*
- *Approve the work plan and budget of the Secretariat and provide oversight of and guidance on its implementation*
- *Mobilize adequate resources for the various activities of the Stop TB Partnership, and identify funding gaps and priorities*
- *Coordinate and promote advocacy and social mobilization in support of the Stop TB Partnership in appropriate fora*
- *Review the progress of the implementation of the Stop TB Partnership and maintain a programme of frequent, high-quality information exchange, including reports of its meeting with all Partners and the public at large*
- *Review the annual financial statement prepared by the Executive Secretary;*
- *Represent the Stop TB Partnership in external fora and events*
- *Adopt appropriate rules or guidelines proper to ensure the proper running of the Stop TB Partnership*
- *Establish such committees as it may deem necessary*
- *Consider and approve any amendment to the Basic Framework*
- *Consider any other matter related to the Stop TB Partnership as may be referred to it by the Chair of the Board or the Executive Secretary*

98. Both GAVI and GFATM are unequivocal that their Boards are the paramount decision-making bodies of the Partnership. Within the Stop TB Partnership there seems broad consensus that the Board carries responsibility for coordinating the various constituencies of the Partnership. There is, however, a wide divergence of views on any hierarchical relationships among Partnership components and whether the Board has a directing or steering function within the Partnership.

99. The issue was explored in a facilitated session of selected Coordinating Board and Secretariat members in August but was not pursued in a subsequent full Board meeting.

100. The question is not academic. It has real significance to keeping the Partnership together and attaining its purpose and mission. It should now be addressed directly by the Board.

101. Although the functions listed above are silent on the matter, it is difficult to see how the Board can execute some – notably the responsibility to set priorities - without exercising a steering or guiding role. Its mode, however, is likely to be one of influence and persuasion rather than exercise of formal authority.

102. Among the Partnership components, the relationship between the Partners' Forum and the Board should be more explicitly defined. The implication of the Forum's function to "make recommendations to the Board on overall progress towards implementation of the stop TB partnership" suggests that the Partners' Forum is a vehicle to allow all stakeholders to express their views, and provide recommendations on partnership policy and strategies. In practice, major policies and strategies have helpfully been put to the Forum for endorsement. Formally strategic and operational decision-making should rest with the Board.

103. The Coordinating Board has a clear, though formally advisory, role in relation to the Secretariat. WHO have made it a condition in hosting the Secretariat that the Executive Secretary and his staff report up the WHO management line, in accordance with WHO Staff Rules.

104. This evaluation recommends that all Task Forces established by the Board should report formally to the Board.

105. The heart of the debate lies therefore in the relationship between the Board and the Working Groups.

106. There is a spectrum of views. At one end is the view that the Board has neither the mandate nor the technical competence to provide effective coordination of what are seen essentially as independent entities dealing with highly detailed scientific matters. The participation of the Working Group Chairs in the Board is sufficient to foster coherence between groups. The proper functions of the Board are not to give direction but to provide moral support, high level endorsement of workplans and advocate for funding. Some in the New Tools Working Groups argue that the Board has not earned a locus. It has not been sufficiently active in advocating for funding of their research projects nor does it contribute to their relatively modest Partnership operating costs. The Working Groups are regularly requested to provide plans and progress reports without getting substantive feedback from the Board.

107. At the other end is the position that the individual Working Groups were not designed to make decisions on behalf of the Partnership and that, without improved coordination and cooperation between the Implementation and New Tools Working Groups, the global targets and the MDGs will not be achieved within their respective time frames. The Board must have responsibility for coordinating all components of the partnership, including the Working Groups, and should do so more effectively than to date.

108. One intermediate suggestion from some is to define a distinction between the administrative functions of the Board and the technical role of the Working Groups. This is superficially attractive, since it is demonstrably clear that the Working Groups are the reservoirs of specific technical expertise. In practice, however, it is unlikely to resolve the issue since few of the strategic decisions required – particularly decisions about priorities – are without technical and politico-administrative dimensions.

109. The evaluation team has concluded that anxiety over possible conflict emerging between the Board and one or more Working Groups, if the Board sought to exercise a coordinating role, should not be exaggerated. Over and above the commitment of most partners to the Partnership, the Partnership structure and operating principles should act to safeguard the integrity of the partnership. It seems improbable that decisions will be reached in the Board without consensus based on the best available evidence, given:

- the presence of the Chairs of the Working Groups as full Board members to guide the Board on scientific and technical issues within their respective mandates
- the combination of high level expertise and consultative processes observed in the Working Groups and Task Forces
- the intimate working relationship with WHO which provides the secretariat for five of the six Working Groups, plus the Board membership of the Director of the WHO Stop TB programme
- the direct link between the Board and the WHO TB STAG whose Chair sits on the Coordinating Board

110. Recommendations

- The question of the extent to which the Coordinating Board has a steering and/or coordinating function among Partnership constituencies and components is a sensitive issue to be handled with care, but the Board should now address it in plenary.
- The evaluation team recognises the divided views on this matter. Its recommendation to the Board is that the Basic Framework be amended to include as Board functions “to guide and provide oversight of the implementation of agreed policies, plans and activities of the Partnership; and to ensure coordination among partnership components”.
- The Board’s exercise of these functions should be conducted with an emphasis on influence and consensus-seeking appropriate to a partnership of this nature. It will be appropriately conscious of the technical expertise of the Working Groups and other relevant technical bodies.
- The relationship between the Partners’ Forum and the Board should be more explicitly defined. The evaluation team sees no reason to amend the functions of the Partners’ Forum which envisage the Forum providing recommendations to the Board on progress towards implementation of the Partnership. It should be explicit that strategic and operational decision-making rests formally with the Board.
- The Board needs to address more aggressively its substantive function to mobilise adequate resources for the various activities of the Stop TB Partnership. It is currently awaiting a full consultancy report on resource mobilisation and agreed at its last meeting to establish a proto Resource Mobilisation Task Force.
- Advocacy by the Partnership should include advocacy for research activities, from basic research to operations research. The Board should ensure some contribution to the cost of New Tools Working Groups’ partnership activities through the budget of the Partnership Secretariat.

Board Composition

**Current Board Composition
Maximum Numbers for Each Constituency**

- 4 *High-burden country representatives - 2 selected from the 2 highest burden countries and 2 others identified by the Board*
- 3 *International organizations with a mandate for health development : WHO, World Bank, UNICEF*
- 6 *Regional representatives - not being WHO staff members but chosen by each of the 6 WHO Regional Offices as technically qualified in TB, having an extensive knowledge of countries in their regions and able to represent various sectors*
- 6 *Chairpersons of the Working Groups as representatives of the working groups, not of their organizations*
- 4 *Financial donors (public and private) selected by the Board*
- 3 *NGOs/Technical Agencies representatives : 1 from IUATLD, 1 from CDC, and 1 selected by the NGO Partners*
- 1 *Chairperson of the WHO TB STAG*

111. The Basic Framework defines a maximum of 27 Coordinating Board members selected to reflect both the major groupings and the diversity of the Partnership. There are provisions for co-option; for example, the Soros Foundation Open Society Institute was co-opted until October 2003.

112. This report has already noted the need to make the Partnership's constituency concept more of a reality, whatever the challenges. Individual Board members carry a particular responsibility for such efforts.

113. The current composition of the Board broadly reflects the nature of the Partnership but there are some well-recognised omissions. Most notable are the absence of representation from the principal clients - TB patients, and the corporate business sector.

114. Finding an appropriate representative for TB patients poses some challenges since TB is usually cured within six months, the disease still carries stigma and TB patient support groups do not exist in the same way as for HIV/AIDS. Nonetheless, there is widespread support for the principle of client representation on the Board and specific names have been suggested.

115. An appropriately selected rotating corporate sector representative would bring a business mindset, a breadth of implementation skills, and global reach in business networks for in kind and other contributions. The World Economic Forum, which has worked with the GFATM, GAIN and Roll Back Malaria and is already working with the Partnership Secretariat, would be willing to run this constituency on the Board's behalf. The benefit of doing this through the Forum has been shown to be getting a committed board member linked in to an existing process to gather broad constituency input ahead of board meetings.

116. Logical allies in the Global Fund and UNAIDS attend meetings but are not formal members. The major resource mobilization exercise to be spearheaded by the Board could benefit from the speedy and more formal inclusion of the foundations.

117. However, there is an issue about the size of the Board. The McKinsey study²⁰ of successful global health alliances advocates keeping the number of people on the main governance body small, and representative if necessary, citing the example of GAIN with its eight-member Board. The Stop TB Partnership Coordinating Board's present membership of 27 should not be enlarged.

118. Accommodating new constituencies would require hard choices among current representatives.

119. The table below sets out three possible options for change alongside the current position.

²⁰ McKinsey & Co, Developing *successful* Global Health Alliances, Bill and Melinda Gates Foundation 2002

CONSTITUENCY	CURRENT	OPTION 1	OPTION 2	OPTION 3
High-burden country representative	4	4	4	3
International agency with mandate for health development	3 (WHO, World Bank, UNICEF)	3 WHO, World Bank, plus one selected	3 WHO, World Bank, plus one selected	2 WHO, World Bank
Regional Representatives	6	3 (possibly non-HBC)	6	0
Chairpersons of the Working Groups	6	6	3	2
Financial donors	4	3	3	2
Foundations	0	1	1	1
NGOs/Technical Agencies	3	3	3	3
Chairperson of the WHO TB STAG	1	1	1	1
People with TB or TB/HIV	0	1	1	1
Corporate business sector	0	1	1	1
GFATM	0	1	1	0
TOTAL	27	27	27	16

120. Option 1 proposes retaining the current number of seats but:

- adding seats for people with TB or TB/HIV, the corporate sector and the GFATM.
- providing permanent seats for WHO and the World Bank with the international agency constituency selecting a third representative (eg UNICEF, UNAIDS etc). The model would be in line with that for NGO/Technical agencies.
- rotating regional representation through three rather than six seats, with a preference for extending membership to countries not on the HBC list. Such countries may in the end make the difference to achieving the global targets and now need to be more closely involved in the development of Partnership strategies and tactics.
- designating one of the current four seats for financial donors as specifically for foundations.

121. Option 2 follows a similar model to Option 1 but proposes:

- retaining all six regional seats
- rotating representation of Working Group Chairs through three seats.

122. Option 3 addresses the issue of size more fundamentally, proposing a 16 member Board

- reducing high-burden country representation from four to three, and dropping regional representatives
- providing permanent seats for WHO and the World Bank and relying on WHO to network among international agencies
- rotating representation of Working Group Chairs through two seats
- reducing financial donor seats to two, plus a third seat for foundations.

A leaner and more executive Board of this kind made up of carefully selected, dedicated members (appointed after extensive consultation within each of the constituencies) could provide a more effective decision making body. However, the essence of partnership lies in relationships. Evaluation interviews suggest that retaining a sizeable Board as a broad and mainly consultative gathering of the constituencies best suits the current state and dynamics of the Stop TB Partnership. Recommendations for improving focus on strategic issues and exercise of oversight are given in section VI.

123. Given the critical role of the Working Groups and the need for close understanding between them and the Board as described above, the evaluation strongly favours Option 1 as maintaining full representation of the Working Groups. The contribution of those Working Group Chairs who currently attend Board meetings is very substantial but the full benefit of this option will only be realised if all Working Group Chairs regularly participate in person.

124. Similarly, individual representatives of high burden countries have attended less consistently than other members. Rectifying this is important if the realities on the ground and the needs of the endemic countries are to be effectively articulated within the Board.

125. Recommendations

- The current composition of the Board in the Basic Framework should be amended to accommodate representation from people with TB or TB/HIV, the corporate sector, the foundations separately from financial donors, and the GFATM formally. All except the GFATM seat should rotate, with a maximum of two terms.
- To avoid increasing commensurately an already sizeable Board, the number of seats for regional representatives should be reduced from six to three, rotating through all six regions.
- Given four dedicated seats for high-burden countries, preference for regional seats should be given to appropriately qualified individuals from non-high burden countries.
- WHO and the World Bank should have permanent seats but the third member for international agencies with a health mandate should be elected by the constituency rather than designated for UNICEF. WHO should take responsibility for supporting an active constituency.

Rotation and selection of Board members

Rotation

126. Board member term of office is for three years, renewable. Representatives of high burden countries, regions, donors and the one rotating NGO post will not normally serve more than two terms consecutively. To refresh the Board, a working assumption of rotation after the first three-year term is advisable.

127. The Basic Framework envisages staggering of terms to avoid mass changes of members. In April 2003 the Board approved a roster for turnover of individual members which is still current but may need tweaking in line with actual terms of office. In the interests of transparency, the Stop TB website should carry a simple table of current Board members and terms of office.

128. While the Chair of the Board will clearly want to brief all new Board members, the outgoing Board member should take responsibility for a seamless handover to his or her successor.

Selection of Board members

129. At present roughly half the seats on the Stop TB Coordinating Board fall automatically to permanent organisations/agencies (WHO, UNICEF, World Bank, IUATLD, CDC), positions held outside the Board (the Chairs of the Working Groups and of WHO's TB STAG) and to the two highest burden countries²¹.

²¹ Current highest burden member representatives are India and Philippines rather than India and China, the actual highest burden countries.

130. The Basic Framework does not cover the selection processes for other Board members. The Board selects two further high-burden countries and four donor representatives; the six WHO regional offices choose a representative each; and NGO Partners select one NGO representative to sit with IUATLD and CDC.

131. The process in each case should be timely, transparent, fair and open.

132. The precise process must be tailored to the needs of the individual constituency but should ideally include an invitation notice which:

- announces the forthcoming vacancy, and sets out the process and timing for selection
- describes the core responsibilities of Coordinating Board members
- specifies the criteria for selection
- invites nominations, supported by details of the partner's commitment to strengthen networks and contribute to the Partnership's objectives, and a CV of the individual nominated

133. This invitation notice should be posted on the Stop TB Partnership's website in addition to being distributed to as wide as possible a range of appropriate potential partners. The Board/constituency should positively seek a balance of new blood.

134. Criteria for selection of the successful candidates from among those expressing interest should be explicit. For example, the NGO constituency has used a weighted questionnaire.

135. General Board membership criteria include commitment to TB action, potential to contribute to the partnership and relevant skill, experience or access to resources. The Board composition of itself ensures a range of technical and geographic representation, but the Board should also give explicit consideration to the balance and dynamics of the Board in appointing individual Board members. For example, in order to ensure an appropriate balance of expertise and/or diversity in the Board at any given moment, specific criteria might be applied to individual Board appointments (e.g. a preference for a constituency representative with advocacy or financial management skills, or a woman rather than a man). Before each such round of rotations, the Secretariat should provide for Board consideration an overall assessment of the ideal balance of skills and other characteristics being sought.

NGO Stop TB Board member: selection questionnaire

Criterion	Maximum points
1. Length of time organisation has existed	5
2. Reach: international/regional/national	15
3. Description/number of members	5
4. Areas of activity	15
5. Projects completed in last 5 years	10
6. Past and possible future contributions to stop TB	15
7. Structure of organisation (providing constitution and byelaws)	10
8. Annual reports for the last two years	5
9. Participation in collaborative projects in last 5 years	10
10. Collaboration with government and WHO (give examples)	10

136. Recommendations

- The public Stop TB website should carry a simple table of current Coordinating Board members and terms of office.
- The processes to select Board members for rotating Board seats should be timely, transparent, fair and open. The criteria for selection should be explicit. Processes will need to be tailored to the needs of the individual constituency but should ideally include Stop TB website publication of an invitation notice with full details.
- To refresh the Board, a working assumption of rotation after the first three year term is advisable.
- Before each round of rotations, the Board should agree an overall assessment of the ideal balance of diversity and expertise being sought, including broader skills in, for example, advocacy or financial management.
- In making new appointments, the Board/constituency should positively seek a balance of new blood.

Handling of Board Business and The Stop TB Coordinating Board Working Committee

137. With the transition to operational mode, it becomes increasingly important for the Board to guide and provide oversight of the implementation of agreed policies, plans, budgets and activities of the Partnership. Effective contributions and timely and legitimate decision-taking of the kind required are difficult to achieve in a Board of 27 members meeting at six monthly intervals. Moreover, the current number and the complexity of Board agenda items make adequate consideration in Board meetings difficult.

138. While there is scope to call more Board teleconferences, this is an imperfect vehicle for consideration of detailed or complex issues, and not well-suited to performance or financial oversight.

139. In 2001 the Board established a Working Committee to work closely with the Secretariat.

Terms of Reference for the Working Committee

- *Assist the Secretariat in preparing the Board meeting, and related background papers*
- *Liase with Board members on any further follow-up*
- *No decision-making authority on behalf of the Board*
- *Board members chosen by consensus from among Board members on the basis of interest, experience and time, with balanced representation from north and south and stakeholder groupings. The Chair of the Board and the agency hosting the Secretariat to be represented on the Committee*

140. The Working Committee has proved a useful support to the Board by undertaking a limited number of process functions. It has focused on preparation for, and follow-up, of Board meetings; the Partners' Forum; the GDF; the partnership evaluation; interim and substantive Executive Secretary appointments; and Technical Review Committee recommendations. The Chair of the Board sits on the Working Committee but does not chair it.

141. The key limitation is that the Committee has no decision-making authority on behalf of the Board. Nor do its terms of reference include any oversight function, although early

papers suggest an original intention that it should guide and evaluate secretariat activities on behalf of the Board.

142. Some strengthening of current Board mechanisms is required to address these issues. If the Board is prepared to delegate defined decision-making authority, some routine issues could be dealt with between meetings and reported to the Board.

143. The Board may wish to consider the options detailed in the table opposite:

- an Executive Committee with delegated authority for decision-making
- the Working Committee for TRC recommendations and pre-processing Board issues, plus an Executive Committee for oversight functions and routine management decisions
- a leaner, more executive Board meeting more frequently (as discussed above)
- current arrangements: Board plus Working Committee without delegated authority

144. One complementary option might be to delegate enhanced authority to the Executive Secretary. Scope for this should be explored when the Board has made a decision on its own Committee operations. However, given the limitations on delegation within WHO and the importance of retaining Board accountability for Partnership issues, it seems unlikely that this option alone can provide a full solution.

145. Similarly, the option of establishing a Finance and Audit Committee or Task Force would meet the oversight function but not assist in relieving the full Board of more routine matters.

146. Overall, it seems preferable to seek a single solution to the greatest number of problems. On balance, the evaluation team recommends the establishment of an Executive Committee of the Board with specified decision-making powers (option 1) as being more in tune with the spirit of the Partnership, easier to achieve and without the risk of duplication. The functions of the Executive Committee are suggested opposite. The current Working Committee would be dissolved on establishment of the Executive Committee.

Handling Selected Board Business: Some Possible Options

- *An Executive Committee with delegated authority for decision-making*
- *The Working Committee for TRC recommendations and preprocessing Board issues, plus an Executive Committee for oversight functions and routine management decisions*
- *A leaner, more executive Board meeting more frequently (as discussed above)*
- *Current arrangements: Board; Working Committee without delegated authority*

i) Option 1: *establish an Executive Committee* of, say, seven Board members representing the main constituencies.

The function of the Executive Committee would be to:

- oversee the Partnership's strategic planning, workplanning and budgeting processes, assess the options and make recommendations to the full Board
- monitor, evaluate and report to the Board on the progress and outcomes of Partnership activities, (working with the Secretariat and, as necessary, with other Partnership components)
- preprocess issues for Board consideration
- on the basis of delegated authority from the Board, determine recommendations from the Technical Review Committee, specified routine management matters and issues judged not to require the consideration of the full Board

Such an approach would allow the Board itself to focus on major strategic issues.

The levels of decision-making authority would need to be specified by the Board within agreed boundaries, eg specified funding limits, and decisions within approved strategies or policies. A requirement would be that all decisions must be reported fully and promptly to the full Board. A quorum of five members would be required for the Committee to take decisions. Such an Executive Committee would supersede the current Working Committee.

ii) Option 2:

- *delegate to the current Working Committee responsibility for determining Technical Review Committee recommendations and preprocessing issues for consideration by the Executive Committee and/or the full Board; and*
- *establish an Executive Committee* with delegated authority from the Board to undertake the planning and monitoring functions set out in Option 1, and to take decisions on specified routine management issues and issues judged on agreed criteria not to require the consideration of the full Board. Again, the Executive Committee should be composed of seven Board members, with a quorum of five needed to take decisions, and should be chaired by the Chair of the Board.

This option, which has been proposed to the evaluation team, would build on current Working Committee arrangements but introduce an Executive Committee to take decisions and fulfil a planning and monitoring function. While this has some merits, there would be a real risk of duplication between the two bodies.

iii) Option 3: if the Board decided to move to *a leaner and more Executive Board* with a limited membership of, say, no more than 16 (see above), they might undertake the range of functions in plenary and meet more frequently. It should be noted, however, that the GAVI Board, which has only 16 members, has nonetheless found it necessary to create a seven-member Board Executive Committee to facilitate the ongoing planning, management and monitoring of GAVI's activities, including Secretariat functions. The GAVI Board has however retained all decision-making authority.

iv) Option 4: retaining current arrangements. This is likely to mean more and/or longer Board meetings. The October 2003 Board meeting was extended to 2.5 days and ideally a further Board meeting is required soon.

147. It is recommended that the Executive Committee should have seven members, with a quorum of five. The current criteria for membership of the Working Committee should apply to the Executive Committee, ie Board members chosen by consensus from among Board members on the basis of interest, experience and time, with balanced representation from north and south and stakeholder groupings. It should include the Chair of the Board as of right, and the Board representative of WHO as the agency hosting the Secretariat. Terms of office should be for two years renewable, staggered from establishment of the Committee.

148. The Chairmanship of such an Executive Committee has been the subject of considerable comment. Options include the Chair of the Board to chair the Executive Committee, the full Board to elect a Chair when appointing members, or the Committee to elect its own Chair.

149. Having the same Chair for the Board and the Executive Committee is a common organisational feature of both the public and private sectors. It is the model adopted by GAVI. It does not entail giving one person decision-making powers which would rest with the Committee as a whole, or with the Board. Having a quorum should safeguard the breadth of representation of interested parties in decision-making. But it has the advantage of locating ultimate responsibility for the handling of Board issues on one person. The role of the Chair is not to do everything personally but to ensure on behalf of the Board that it is being done.

150. Nonetheless, in a partnership like Stop TB, other factors are also important, particularly if the Committee is to have decision-making authority, (e.g. for approving TRC recommendations, signing off proposals for expenditure within plan, approving increases to Secretariat staffing not covered by plan). These factors include the engagement of a range of partners in key issues and a balance of power among them. The balance of opinion among those who commented on the proposal was that the Board should elect the Chair of the Executive Committee for a fixed term of two years renewable. The Chair of the Board would be eligible for election.

151. If the Chair of the Executive Committee is someone other than the Chair of the Board, there will need to be a very close working relationship between the two Chairs. There should be some careful delineation of their respective roles and responsibilities for process issues and for the Executive Committee's preliminary oversight function. The Executive Secretary would need to relate to two key Chairs as well as (for different purposes) the WHO Stop TB Director. All concerned should act to facilitate this complex set of relationships.

152. Recommendations

- With the transition to sustainable operations, the Board should consider and determine options for strengthening Board oversight mechanisms, streamlining Board consideration of issues through pre-processing by Board members, and delegating authority for decision-making on routine matters within agreed limits.
- To handle these functions, the evaluation team recommends the establishment of a Executive Committee of the Board with defined delegated authority for decision-making. The Executive Committee should be composed of seven Board members, with a quorum of five needed to take decisions. The current Working Committee would be dissolved.
- After appointing the members of the Committee, the Board should elect its Chair for a fixed term of two years renewable.
- If the Board accepts the recommendation for an Executive Committee, it should establish an ad hoc Board Task Force to develop proposals for the extent of the Executive Committee's delegated powers, to be considered at the Board's meeting in Spring 2004. It is critical that Board members have ownership of this process.

IV: INSTITUTIONAL ISSUES: WORKING GROUPS AND TASK FORCES

Working Groups

Number and focus of Working Groups

153. The Basic Framework describes the Working Groups as the primary means for coordinating activities mandated by the Board. Interviewees variously described them as the engine or the pillars of the Partnership indicating the critical role they play. There are currently six.

Stop TB Partnership Working Groups	
Implementation Working Groups	New Tools Working Groups
DOTS Expansion	New TB Diagnostics
DOTS-Plus for MDR-TB	New TB Drugs Development
TB/HIV	TB Vaccines Development and Coalition

154. The Global Plan to Stop TB maps input from the Working Groups covering major aspects of TB prevention and control. The Working Groups have been crucial in development of TB prevention and control policy, strategies, in setting standards of practice in the areas of research and clinical care, and public health related to TB.

155. The outputs and products of the Groups find ready translation into concrete activities that support national TB control activities through the partnership - a network that is much wider than any one of the constituencies or partners can provide. This has facilitated consensus building and acceptance as well as consistency and coherence in what is being recommended for adoption by countries, an advantage that is appreciated by the TB endemic countries.

156. There is strong agreement that these are currently the key areas for technical activities. Longer-term it is helpful to ensure that bodies like Working Groups do not outlive their usefulness. One option would be to limit their life to the term of each 5-year Global Plan with an automatic sun-setting clause, subject to review of relevance and efficacy for the next Plan.

157. This would not prevent a decision at any time that a Working Group is no longer needed. It has already been agreed that DOTS-Plus should be mainstreamed into the DOTS strategy by 2005, with a merger of the two Working Groups.

158. During the evaluation, the suggestion was made that all six Working Groups might be consolidated into two, one for implementation and one for research and development. The general consensus is that it is too early for this more general consolidation.

Functions and operation of the Working Groups

159. The Basic Framework sets out some generic proposals for Working Group composition, functions and operation.

Basic Framework: Generic Functions of the Working Groups

- Map out activities in the specific area, including activities by different Partners, policy and research developments, opportunities for further action, and resource needs
- Plan, implement and monitor coordinated action, building on the mandates, interests and comparative strengths of the different Partners
- Report to the Board and the Forum on progress, constraints and assistance required
- Coordinate with other Partners, Working Groups or other committees to ensure synergism of activities, including advocacy, communication, and resource mobilization

160. The six Working Groups predated the formal establishment of the Global Stop TB Partnership. Following the advent of the Global Stop TB Partnership, the predecessor bodies with their autonomous governance structures, secretariats and funding sources were formally transformed into the Working Groups of the Partnership, with limited structural or administrative adjustments. The Working Group on New TB drugs is in fact the Global Alliance for TB Drug Development, a non-profit, section 501(c) 3 organisation with its own governing board and CEO who serves – and must necessarily serve - as the Chair of the Working Group for so long as this arrangement is in place.

161. The other five Working Groups are - historically and continuingly - linked closely with WHO which hosts their secretariats. This intimate relationship is not seen as posing significant difficulties for either side. In the interests of effective partnership, assurance of independence, and avoidance of conflict of interest, the positions of Working Group Chair and Secretary should not be held simultaneously by people from the same institution.

162. Inevitably this direct conversion into Partnership Working Groups has resulted in some organisational oddities but these have been outweighed by the benefits of a ready-made Partnership structure focused on the key necessary elements. The evaluation concurs with the conclusion of the Secretariat Project on “Re-examining the Roles and Responsibilities of the Stop TB Working Groups” that uniformity in the structure of the Working Groups is not necessary. There is sufficient diversity in each of the areas represented by the groups that differences in structure are not undesirable.

163. Absorption into the Partnership has brought about some degree of interchange across the various Working Groups but there remains critical need for the development of a single cohesive vision of how the various streams of activity come together to deliver the Partnership’s mission. The Global Plan is a major achievement but it is nonetheless a compilation of individual Working Group workplans rather than a synthesis. There is need for more effective coordination.

164. In addition, there is a strong sense among some partners that the New Tools Working Groups have not been given sufficient attention by the Board. It has been suggested that the horizon for delivery of the new tools has been seen as relatively so distant (diagnostics by 2005; drugs by 2010 for registration and 2012 for availability to high burden countries; vaccines by 2010) that attention has focused predominantly on the immediate epidemic in countries. This, it is suggested, has created a mind set amongst many Board members that DOTS Expansion is the Partnership, and anything not directly related to it is accordingly treated as of secondary importance.

Evolution of the DOTS Expansion Process

165. DOTS Expansion is the common pathway to the implementers at country level. However, the strategy must be seen as dynamic. Development of new tools and lessons from operational research in the field continuously feed into it to increase its acceptability and effectiveness.

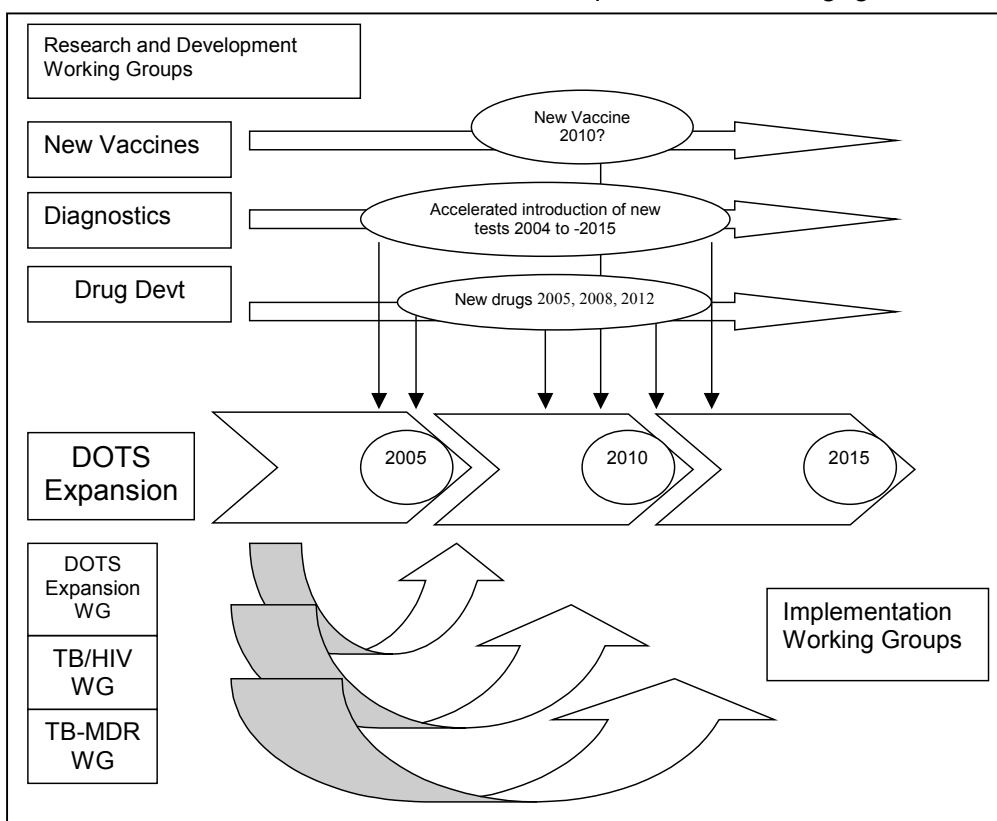
166. A comprehensive vision of the long-term strategy is critical. Given the long-lead times for development, decisions and investments are already being made. Some of the milestones are no longer very far away, and there is need for concerted action on trials.

167. There is a related issue about priorities. For example, the Board was advised in October 2003 that improved diagnostic tests suitable for use in developing countries are already available but have not been seriously considered for accelerated introduction. Accelerated development of new, more effective, affordable and easier to use diagnostic tools would help reduce the increasing pool of infectious cases that is fuelling the TB epidemic and provide an additional tool to fight TB/AIDS. Prioritising the introduction of new

drugs or formulation of new combinations of existing drugs could simplify treatment regimens, shorten treatment duration and thereby increase patient compliance and make patients non-infectious more rapidly - thus increasing cure rates and at the same time minimizing MDR-TB. It has been suggested to the evaluation team that these areas have not been afforded an appropriate degree of priority and support by the Board.

168. This is a moving picture. Both the 2nd Ad Hoc Committee on the TB Epidemic and the Board have been looking at approaches for improving coordination and cooperation among, and between, the Implementation and New Tools Working Groups. The Board has asked for an action plan on the 2nd Ad Hoc Committee recommendations to be prepared. The Secretariat project on “Re-examining the Roles and Responsibilities of the Stop TB Working Groups” has recently reported to the Board.

169. These moves need to be demonstrably owned at Board level. Presentation of reports from each of the Working Groups is now to be a regular feature of Board meetings. This must not become a sterile exercise. What is required is active engagement and response.



170. Recommendations

- Working Groups should be limited to the term of each 5-year Global Plan with an automatic sun-setting clause, subject to review of relevance and efficacy for the next Global Plan.
- The positions of Working Group Chair and Secretary should not be held simultaneously by people from the same institution.
- A comprehensive and cohesive vision of how the various Working Group streams of activity come together is urgently required.

- The evaluation team endorses the recommendations from his project presented by Dr Hopewell to the October 2003 Board meeting, in particular that:
 - the potential contributions of new tools and approaches should be incorporated into descriptions of overall strategies to meet global targets. Where feasible, estimates of their impact should be included in disease trends
 - progress towards reaching targets for development of new tools should be included in annual Partnership reports
 - there should be an annual meeting of the Chairs and focal points of all six Working Groups
- These activities should be supported by the Secretariat. A full-time position to provide support and facilitation to the Working Groups is just being established.

Task Forces

171. The Basic Framework includes Task Forces on Financing and on Advocacy and Communications in its organogram but does not otherwise discuss Task Forces. The Financing Task Force has never been operationalised as such.

172. There are no clear specifications for Task Forces. In general, they are used for ad hoc, time-limited tasks. For example, in 2003 there have been Task Forces for the Executive Secretary interim and substantive appointments.

173. However, the Advocacy and Communications Task Force is of a different nature. Its task represents a core stream of continuing Partnership activities, as would any Task Force on resource mobilisation, superseding the Donors' Task Force.

174. It has been argued that Working Groups must be reserved for specific technical/implementation activities, and that cross-cutting activities in support of all Working Groups – like advocacy and resource mobilisation – should therefore be handled in Task Forces.

175. As a matter of principle, the evaluation team has reservations about this approach. The crucial need is to ensure that the designated structure provides adequate support and oversight for the function. One key distinguishing feature between a Working Group and a Task Force is that Working Group Chairs have a seat on the Coordinating Board.

176. Recommendations

- Core Partnership activities requiring active and continuing Board engagement and oversight should be eligible to be Working Groups, regardless of whether their functions are cross-cutting.
- Task Forces should be used for ad hoc tasks or activities which do not require direct and continuous Board engagement.
- The Terms of Reference for all Task Forces should set clear time-limits for the life of the body. Any long-running Task Forces should, like Working Groups, be limited to the term of each 5-year Global Plan with an automatic sun-setting clause, subject to review of relevance and efficacy for the next Plan.
- Appointment of members to Task Forces should be transparent and fair.
- Task Forces should be accountable to the Coordinating Board.

Advocacy, communications and social mobilisation

177. The state and status of advocacy and communications within the Partnership, and of the Advocacy and Communications Task Force, featured prominently in evaluation fieldwork. Many interviewees expressed the view that this area of activity has tended to be marginalized and has not received the attention and support necessary for effective implementation. The evaluation shares the view of the 2nd Ad Hoc Committee on the TB Epidemic which has recommended that structures within the Stop TB Partnership dedicated to advocacy and communications must be strengthened and formalised at the global level.

178. Within the current Task Force on Communications and Advocacy there are several sets of important skills. The two key areas are advocacy for resource mobilisation and communications for social mobilisation. Both areas are political and both involve advocacy and communications skills, even if the approaches often differ. There has been some debate about separating the activities into different Task Forces or Working Groups. At this stage it seems premature to recommend separation and such a move may well be detrimental to the kinds of synergy required in Stop TB. Other recommendations in this report should help to provide the vision building and task allocation needed to ensure successful collaboration.

179. It is widely agreed that information, communication, advocacy and social mobilisation are central to all the activities of the partnership, cutting across all components of the partnership from the global to the community level. The country visits indicate that where advocacy and communications efforts of the Partnership have been effective, the commitment of governments has demonstrably increased.

180. Yet there is a marked absence of an active global partner specialising in communications and advocacy. This is reported to be a major handicap to a more effective articulation of the work and needs of the Partnership and to the provision of more timely and effective support to TB affected countries.

181. In order to expand capacity rapidly, a more detailed plan for advocacy and communications needs to be developed. It should identify clear areas of need and potential collaboration with agencies like the Johns Hopkins University's Health Communications Partnership (JHU-CCP), the Rockefeller Communication for Social Change Consortium, the Massive Effort Campaign, Results and Tb Alert. Greater involvement in advocacy and social mobilisation activities from other more technical orientated agencies such as CDC, KNCV and the IUATLD should be encouraged, when doing programme reviews, advising on programme development and holding training sessions.

182. An approach of this kind is vital if Stop TB is to position itself as a major global brand. It would support not only advocacy and communications for global resource mobilization, but also capacity-building at country level for advocacy, communications and social mobilization efforts.

183. Building stronger capacity at country level will be essential if Stop TB goals are to be achieved. The ideas on developing and expanding partnerships especially involving NGOs and civil society as set out in the draft StopTB/WHO document "The Power of Partnerships" should be explored at regional and country level. These developments imply an expanded partnership-building role for country TB managers who, while providing technical leadership and coordination, must also help to promote the ideas and understanding of the implications to senior management, politicians, partners and other stakeholders.

184. Recommendations

- Advocacy, communications and social mobilisation need a higher profile and more effective handling within the Partnership.
- The evaluation endorses the recommendation of the 2nd Ad Hoc Committee that global level structures must be strengthened and formalised.
- Specifically the Advocacy and Communications Task Force should be reconstituted as a formal Working Group of the Stop TB Partnership with representation on the Coordinating Board in the person of its Chair. Given the Board's function to coordinate and promote advocacy, the Terms of Reference of this Working Group should specify that it reports to the Coordinating Board.
- The Working Group should develop a more detailed plan for advocacy and communications. It should identify areas of need and potential collaboration with active global partners specialising in communications and advocacy, like the Johns Hopkins University's Health Communications Partnership (JHU-CCP), the Rockefeller Communication for Social Change Consortium, the Massive Effort Campaign, Results and Tb Alert. .(– I think we can omit this repetition HN) Greater involvement in this area from other more technical orientated agencies such as CDC, KNCV and the IUATLD should be encouraged.
- The ideas on developing and expanding partnerships especially involving NGOs and civil society as set out in the draft Stop TB/WHO document "The Power of Partnerships" should be explored at regional and country level.

V: INSTITUTIONAL ISSUES: THE SECRETARIAT

185. The evaluation was asked to examine in detail the composition, staffing, structure and work schedules of the Secretariat.

Functions

186. The Secretariat is the administrative component of the Stop TB Partnership. Its purpose is to support the Stop TB partners in fulfilling the Partnership's mission.

Secretariat functions as defined in the Partnership's Basic Framework

- *Prepare, for approval by the Board, an annual work plan and budget for the Stop TB Partnership, including plans and budget for the Secretariat, and any group established by the Board*
- *Coordinate and monitor the progress of activities*
- *Collect and collate information and disseminate them within and outside the stop TB Partnership and its components*
- *Develop communication strategies to support its campaign, promoting greater awareness of the social, economic and political aspects of the global TB epidemic*
- *Maintain close and regular contact with the Working Groups to facilitate coordination and support their work*
- *Provide the administrative support to the Board, the Working Groups and the Forum*
- *Contract for procurement, quality control and monitoring/evaluation functions of the Global TB Drug Facility with suitably pre-qualified agencies, in accordance with the policies of the host Organization (i.e. WHO)*

187. A slightly different definition of secretariat functions and responsibilities currently on the Stop TB partnership website puts greater emphasis on accountability mechanisms and on mobilising financial and other resources at three levels:

- general resource mobilisation to promote increased investment in TB through a wide range of local, national and international funding mechanisms
- specific resource mobilisation for specific global initiatives, such as the GDF and the Stop TB Trust Fund
- specific resource mobilisation for the activities of the Secretariat itself.

188. This report has already made clear the need for more, and more effective, Partnership activities in relation to resource mobilisation, advocacy and communications. Both are areas involving the Board as well as the Secretariat. It is vital that the strategies for these closely related areas are fully articulated. They must then be underpinned by a clear delineation of the respective roles and responsibilities of the Board, of any relevant Working Group or Task Force and of the Secretariat. The Executive Secretary should develop for Board consideration a set of proposals drawing on the recommendations of current relevant reports (including the reports of the 2nd Ad Hoc Advisory Committee, the resource mobilisation consultancy and this evaluation).

189. Subject to the outcome of that work, the Basic Framework specification of Secretariat functions should be amended in line with the website specification to reflect more fully the Secretariat's responsibilities for resource mobilisation, advocacy, communications and social mobilisation, and for accountability mechanisms (such as a report on Secretariat activities to each regular Board meeting and an annual report on the activities of the Board and Secretariat).

190. The Partnership Secretariat serves the biennial Partners' Forum, the Board (usually two meetings per year), the Working Committee (occasional meetings and, say, about seven teleconferences per year on the basis of the notes posted on the website) and a number of Task Forces and ad hoc committees (eg, in 2003 for the interim and actual appointments of

the Executive Secretary, the evaluations of the GDF and of the Partnership, and more continuous Task Forces like that for Advocacy and Communications). It should serve a Board Executive Committee, if established. While the Secretariat has a function to maintain close contact with the Stop TB Partnership Working Groups, the secretariats for those groups are provided by partners (WHO, plus the Global Alliance for TB Drug Development/CDC).

191. It is not clear that the Secretariat does at present prepare for approval by the Board an annual workplan and budget for the Partnership, including not only Secretariat bids but also plans for any group established by the Board (ie the Working Groups). The need for such an annual exercise is recommended in section VI on partnership processes.

192. The function “to coordinate and monitor the progress of activities” is ambiguous. If it refers to coordinating the full range of activities planned by the Partnership to achieve the Partnership’s targets, it is unclear what locus the Secretariat has, except in support of the Board. The Secretariat has no formal authority over the Working Groups or Task Forces. This function should be clarified. An alternative wording of the function might be “to support the Board in coordinating and monitoring activities of Partnership bodies, in pursuit of Partnership targets”.

Functions of the Executive Secretary

193. The functions of the Secretariat and those of the Executive Secretary should be considered together.

194. Formally, the Executive Secretary is responsible for the overall management of the Secretariat and specifically for:

- directing production, implementation and monitoring of the Global Plan to Stop TB
- coordinating partnership building through mobilizing and coordinating partner organizations involved in TB control and related activities
- directing developments, strategies, implementation and evaluation of advocacy and communications
- directing development and management of the Global Drug Facility²²

195. Support to the Board on resource mobilisation should now be included as a key responsibility.

196. More broadly, the Executive Secretary has to be the dynamo for the Partnership. Board members may be committed but are always part-time, with their own jobs to do. Being Executive Secretary is a demanding role: part visionary, part practical manager, part politician, part fund-raiser.

197. The new Executive Secretary has the support of many Board members to provide leadership and drive for Partnership activities, working closely with all its component parts. Given the Secretariat’s track record of success to date in establishing mechanisms like the GDF, they look to it to play an activist role in shaping strategies, securing consensus and implementing initiatives.

198. How far the Board will feel comfortable to go beyond this to formal delegation of authority should be considered – by the Board - in the context of the consideration recommended above of delegation of authority to an Executive Committee. It is notable, for example, that the GAVI Board has not delegated decision-making powers either to its Executive Committee or its Executive Secretary.

²² WHO vacancy notice HQ/03/TBP/FT238

199. The major spending decisions from the Secretariat's budget at present relate to TRC recommendations. It could be argued that the Executive Secretary should determine them on the basis of the TRC's expert advice and clear funding principles to be established by the Board. But these are critically important issues for the Partnership's relations with countries, and the evaluation team would favour their being taken by the Executive Committee as representative of partners.

The Global TB Drug Facility and the Green Light Committee within the Secretariat

200. At the Coordinating Board meeting in April 2003, the Board decided on the basis of the GDF evaluation that the GDF should continue to function as part of the Partnership Secretariat and to report to the Executive Secretary. The Board mandated the Acting Executive Secretary to recruit a new GDF manager as soon as possible, and other staff as needed. The evaluation team recommended to the Board in October that filling the GDF manager position with a suitably experienced candidate was an outstanding and immediate priority. Support for the Green Light Committee is now managed in tandem with the GDF.

201. It has been suggested in the course of fieldwork that the Secretariat's responsibility for the Global Drug Facility and the Green Light Committee might be transferred to WHO or to the DOTS Expansion Working Group.

202. This too has been an area of rapid development during the evaluation. Consideration is currently being given to the establishment of GDF-type mechanisms for HIV/AIDS and malaria. The McKinsey report found that additional GDFs were both desirable and feasible but noted that the approach should be adapted to the needs of the disease in question. Options are now being explored under working groups established as part of the 3x5 Initiative, with inputs as necessary from the Stop TB Partnership. Although thinking is still at an early stage, it is important to consider the implications for the TB GDF.

203. In governance terms, one option would be to transfer the TB GDF to WHO and group all three GDFs as separate units within the relevant WHO cluster. This would be consistent with the principle that operational functions of global partnerships should generally be taken on by individual partners.

204. In the longer-term, when the TB GDF has reached steady state, transfer may be an option to consider. But now is not an opportune moment to move the GDF, which needs the close involvement of the Stop TB Partnership Coordinating Board in determining future strategy and funding. Immediately it also needs strong operational leadership, oversight and support from the new Executive Secretary and a new GDF manager. Transfer now could be disruptive and possibly undermine the hard won links which have been built with country programmes. All these factors suggest that the present governance arrangements should be maintained at present. It is understood that this also reflects the current thinking of the working group.

205. In terms of operational impact, the GDF evaluation found that the existing TB GDF could gain significantly from the establishment of additional GDFs through greater leverage at the country level, from reputational benefits and from the presence of economies of scope and scale (notably in areas such as administrative support including information systems, global data collection, brand building and advocacy). Downside risks relating to a possible loss of focus and diversion of expertise and funds away from TB were felt to be low. The extent of the possible benefits is not yet clear and will depend on the models adopted. It may prove necessary to establish additional institutional arrangements to ensure such benefits are fully captured. The Stop TB Partnership would clearly need to be involved in the establishment and operation of such arrangements.

206. It is recommended that:

- the GDF and support for the Green Light Committee should at present continue to function as part of the Stop TB Partnership Secretariat, notwithstanding consideration currently being given to the establishment of GDF-type mechanisms for HIV/AIDS and malaria
- the position of GDF manager should report to the Executive Secretary, as decided by the Coordinating Board in April 2003, and should be filled as a matter of urgency

Location of the Partnership Secretariat within WHO

207. In establishing the Global Stop TB Partnership, it was decided not to create a legal entity. It therefore has no powers of its own to employ staff, enter into contracts etc. The Secretariat is hosted by WHO who undertake those functions on the Partnership's behalf. GAVI is similarly hosted by UNICEF and Roll Back Malaria also by WHO. One consequence is that the staff of the Secretariat are actually WHO staff, and that the Coordinating Board is formally advisory to WHO in relation to the Secretariat, including the operation of the GDF which accounts for the bulk of Secretariat expenditure and operations.

208. The general advantages of such hosting arrangements are access to infrastructure, systems (human resources, legal, financial etc), technical support from an existing institution, the ability to establish operations quickly. This enables the Partnership to operate with a smaller Secretariat than would otherwise be the case. Specific additional benefits in UN agencies are tax-free salaries and immunities for staff. The main general downside is that the systems may not be ideally suited to the needs of the Partnership, and there may be a risk that the mission of the Partnership will not be seen as a high priority – though in this case, Stop TB is also a priority of WHO which has its own department under the same name (a source of brand confusion).

209. There are several clear advantages for both parties in the present arrangements for the Stop TB Partnership Secretariat. WHO has a special role as a partner and as the global public health authority with a mandate from its member countries. WHO is empowered to make policy and positioned to assist in implementation of strategies that are in line with its policies. The partnership benefits from easier access to countries through WHO's regional and country networks, and through direct funding and logistics support from the Organization. At country level, great appreciation was expressed about the very substantial contribution WHO makes to the Partnership which has profited from the WHO brand name. Within WHO HQ, the Secretariat has access to a wide range of technical expertise. WHO in turn benefits from speedier development of global consensus on TB-related strategies and policies, global advocacy and increased donor support for its coordinating functions.

210. Against the background of strong technical relationships, the history of resolving the legal and administrative arrangements between the Partnership and the WHO has been fraught and immensely time-consuming for all concerned. They are not yet finalised. No general Memorandum of Understanding (MOU) between the Partnership and WHO has been signed. The Basic Framework sets out the Partnership's understanding but has not been formally ratified by WHO. A time-limited MOU relating only to the GDF was signed, but now needs renewal. The Coordinating Board has felt impelled to set up a Task Force to seek to resolve difficulties encountered in operating a Partnership Trust Fund which it established at the World Bank, apparently without the involvement of WHO. Contract processes (dealt with in the GDF evaluation) and human resources procedures have been a source of tension.

211. To avoid continuing waste of effort, these issues now need to be tackled intensively and with good will on both sides to bring them to resolution, including a general MOU between the Partnership and WHO, and a renewed GDF MOU if separate agreements are

required. The remit of the Trust Fund Task Force could be extended to provide the Partnership input, supported by the Secretariat.

Financial aspects

212. In return for hosting the Secretariat, WHO levies a Programme Support Charge (PSC) on all donations, generally of 13%, (or 6% for drug procurement under GDF). This charge is to cover general support costs such as accommodation, lighting, heating, and professional support, e.g. legal, financial, human resource and administrative services. One specific cause of concern among donor partners has been that these payments seem too high in relation to costs actually incurred by WHO.

213. WHO estimates that indirect costs incurred by WHO in 2001/02 amounted to some \$1.8m compared to PSC revenue of some \$2.0m. WHO also provided technical support inputs to the Partnership of \$4.3m over the same period (for detail, see Annex J).

214. This suggests that WHO makes a substantial net financial contribution to the Partnership and that the PSC revenue broadly offsets the indirect costs incurred by WHO. Attempts to avoid PSC through the establishment of the Trust Fund would, on this basis, appear unwarranted. This finding is heavily dependant upon the level of grant support for DOTS expansion through the GDF. If this were to increase (decrease) significantly, it could – depending on the level of services consumed - result in a net financial surplus (deficit) for WHO in its hosting role.

215. In principle PSC paid by the Partnership should broadly balance the costs incurred by WHO in providing support services of an appropriate quality. This balance should be reviewed on a periodic basis (eg twice during the Global Plan period, at the mid-term review and the final evaluation).

Human resource aspects

216. The human resource aspects are considered in more detail below, with specific recommendations. Both the Secretariat and WHO have met frustrations. There is scope for the Secretariat to assist itself considerably by developing a human resources strategy and working closely with the WHO administration to realise it. There is also scope for WHO to exercise some flexibility, and take action on behalf of all its clusters to reduce unconscionably long recruitment delays.

Governance

217. The GDF evaluation concluded that the GDF's governance model had worked moderately well, balancing the roles of WHO who provide the legal umbrella for the GDF and of the Stop TB Partnership who provide funding and technical assistance through partners. It recommended that the model continued to be appropriate, though there was need for WHO and the Coordinating Board to clarify their respective roles and establish clear accountability for decision-making, oversight and legal liability.

218. Unsurprisingly, this evaluation has reached a similar conclusion in relation to the rest of the Secretariat. One risk is that WHO as host organisation and line management might be seen as dominating the Partnership Secretariat, or even the Partnership. In practice both evaluations have found that WHO has to date played a constructive and relatively hands-off role in governance.

219. Other options are possible. The Partnership could, like the GFATM, seek to be established a legal entity able to handle its own affairs. Or it could remain a non-legal entity, with its Secretariat hosted by another partner with less rigid procedures. The evaluation team was asked by the Evaluation Steering Committee not to explore these options. But it

notes for the record that, where the issue has arisen, Board members remain of the view that the Secretariat should be hosted in WHO despite the administrative frustrations.

The Partnership Executive Secretary

Executive Secretary reporting lines

220. As set out in the Basic Framework, the Executive Secretary reports to the Director of Stop TB and the Director General of WHO, not to the Partnership Coordinating Board. This is in contrast with the Executive Secretary for GAVI who reports to the Chairperson of the GAVI Board, while being a staff member of UNICEF which hosts the GAVI Secretariat.

221. Ideally the Executive Secretary of the Stop TB Partnership should similarly report to the Chair of the Partnership's Coordinating Board as representative of the whole Board. The evaluation team was advised during fieldwork that this is not compatible with being a staff member of WHO since the Executive Secretary – like other members of the Secretariat – is subject only to the authority of the Director-General and the technical and administrative direction of his Director. Formally, as WHO staff, they may neither seek nor accept instructions in regard to performance of their duties from any government or authority external to WHO (Staff Rule 1.10 which seeks to ensure the independence of the World Health Organization, and to protect its staff from undue influence). This reporting line to WHO management is seen as part of the trade-off in having the Secretariat located in WHO.

222. In practice, the arrangement has been made to work through a strong sense of partnership and diplomacy by the Partnership Executive Secretary and successive WHO Stop TB Directors. WHO's general stance is seen as operating through the Board and other Partnership components as a (very influential) partner rather than directly through the Secretariat as a line manager. In the absence of robust institutional mechanisms to protect the Secretariat in the event of differences of view between the Board and WHO, there is a heavy onus on both the Board Chair and the WHO Director of STB to be alive to the sensitivities and to resolve issues speedily among partners in the Board.

223. It should be noted that, towards the end of the evaluation, the WHO post of the Executive Secretary for Roll Back Malaria was advertised²³ on the basis that s/he would be accountable to and report functionally to the RBM Partnership Board and ultimately the RBM Partners' Forum. S/he would report administratively to the Director of WHO's RBM Department. Subsequent discussion with WHO's central Human Resources Services indicated that the RBM advertisement was not in line with WHO Staff Rules and that the appropriate formulation should be that the Executive Secretary for RBM should operate "under the guidance of the RBM Board and report to the WHO Director, RBM, on both technical and administrative matters".

224. The evaluation recommends that:

- the posts of Executive Secretary for the Stop TB Partnership and for the RBM Partnership are directly analogous in respect of reporting lines and the same conditions should apply to both
- ideally the Executive Secretary of the Stop TB Partnership should report to the Chair of the Partnership's Coordinating Board as representative of the whole Board. However, on current WHO advice, the Executive Secretary of the Stop TB Partnership must, under the guidance of the Stop TB Coordinating Board, report formally to the WHO Director of Stop TB, so long as s/he is a WHO employee. This position should be reconsidered if a different outcome is adopted in relation to RBM
- whatever more detailed guidance WHO provides on the practical meaning of "under the guidance of the Board", goodwill between the Director of Stop TB and the Coordinating

²³ WHO vacancy notice HQ/03/HTM/FT427

Board are critical to making these reporting arrangements work in practice. There is no evidence of problems to date but there must remain potential for difficulties. It should be the responsibility of the Chair of the Board and the WHO Stop TB Director to spot and resolve problems swiftly, not to leave the Executive Secretary in a difficult position. The WHO Stop TB Director could seek the advice and suggestions of the Board Chair in setting the Executive Secretary's annual objectives and on his/her performance appraisal, under WHO's Personnel Management and Development System (PMDS)

Executive Secretary appointment process

225. During the evaluation, Dr Marcos Espinal was appointed to the post of Partnership Executive Secretary on a two-year fixed term appointment. The appointment was made using an innovative process which could be a model for other Partnerships housed in WHO. Formally, the Executive Secretary is appointed by the Director-General of WHO in consultation with the Coordinating Board. The process adopted was closely coordinated between the Coordinating Board and WHO, while meeting WHO requirements: see Box below. Both the Partnership and WHO Human Resources Services perceive the approach as having worked well – albeit at the cost of short-listed candidates having to face two final interview panels.

Executive Secretary Selection Process

- *Vacancy notice issued by WHO and also disseminated by the Partnership network*
- *All CVs received reviewed by Coordinating Board Panel*
- *Teleconference-interviews of top 9 candidates produced shortlist of 4 candidates*
- *Short-listed candidates interviewed face to face by Coordinating Board Panel, then WHO Selection Panel which retained authority for reaching an independent recommendation*
- *Both Panels came to consensus*
- *WHO Director-General approved the appointment*

Level of appointment

226. The terms of reference and a grading of P6 for the Executive Secretary post were determined for the recent appointment exercise.

227. We should, however, record our conclusion that, assessed against WHO's post classification criteria, the post of the Stop TB Partnership's Executive Secretary properly merits the grading of at least Director 1 (D1) rather than P6, given the level of responsibilities, his very public position as the visible embodiment of the Partnership, and the wide range of tasks beyond WHO in relation to partners and countries. These are in addition to considerable internal management responsibilities, including oversight of a sizeable Secretariat with operational functions. By comparison, the GAVI Executive Secretary is a higher-graded Director 2 (D2) within UNICEF but he has no supervising Director.

228. An upgrading of the Stop TB Executive Secretary from P6 to D1 would have no financial implications for the Partnership or the postholder, since D1s and P6s are paid at the same rate. WHO central Human Resources Services have advised that there would be no bar to the Executive Secretary as a D1 reporting to the Director of Stop TB who holds the higher grade, D2. Such an upgrading would provide headroom for higher graded positions for some team leaders (eg a P6 post for the GDF manager) to attract candidates of appropriate stature and experience.

229. The evaluation team had originally concluded that the Director of Stop TB and the Partnership Coordinating Board should review the position in one year, based on evidence of the Executive Secretary's responsibilities and duties in the interim. It is understood that a new post classification system is due to be introduced from 1 January 2004.

230. However, the post of Roll Back Malaria Executive Secretary discussed above has now been advertised as a D2, with the possibility of appointment as a D1 depending on the qualifications and experience of the selected candidate. On the face of it, these two Partnership Executive Secretary posts have very similar functions and responsibilities and merit the same grading.

231. It is recommended that there should be an early review of the grading of the post of Stop TB Partnership Executive Secretary, with a view to upgrading to D1 as a minimum (or D2 if that is the grading confirmed for the post of RBM Executive Secretary with its broadly analogous responsibilities).

Secretariat Staffing

Numbers, grades and costs

232. The Partnership's Basic Framework envisaged that the Secretariat would be led by the Executive Secretary and 'comprise such staff as the Board may recommend'. An earlier Governance Mechanisms paper and the current website section on the Secretariat propose that a reasonable staffing level for the Secretariat would be around 15, with limited secretarial assistance. This apparently excludes GDF staffing but assumes four professional staff to support the Working Groups and one to cover finance and personnel issues. In practice the Working Groups are serviced by partners and the Secretariat is just establishing one professional post to facilitate coordination among the Working Groups.

233. In October 2003, the total Stop TB Secretariat complement of staff of all kinds plus vacancies amounted to 33.55 fte (22.55 professional, including two part-timers, and 11 general support staff). It had 20 positions (13 professional and seven general staff) for partnership support and innovations, advocacy and general management functions. In addition, the GDF section of the Secretariat had 14 positions (10 professional staff and four general staff). An overview is given below, with a full breakdown in Annex E.

Total staffing complement (fte)	P6	P5	P4	P3	P2	G5	G4	G3	Total P	Total G	Total
Partnership support and innovations		2.55	1		1		2		4.55	2	6.55
Advocacy and communications		1	2		1		2		4	2	6
General management and administration	1	1		2		2	1		4	3	7
Global Drug Facility		3	3	2	2		3	1	10	4	14
Total figures	1	7.55	6	4	4	2	8	1	22.55	11	33.55

Total staff in post (Oct 2003)	P6	P5	P4	P3	P2	G5	G4	G3	Total P	Total G	Total
Partnership support and innovations		2.55	1		1		2		5	2	6.55
Advocacy and communications		1	1		1		1		3	1	4
General management and administration	1	0		2		2	0		3	2	5
Global Drug Facility		1	3	2	2		1	1	8	2	10
Total figures	1	4.55	5	4	4	2	4	1	18.55	7	25.55

234. Comparisons with other Partnership Secretariats need to be treated with care, given the differences in functions – and particularly operational functions like the GDF. And there are differences in philosophy. The GAVI Board, for example, explicitly seeks to mainstream activities to partners and to maintain a very lean secretariat. In October 2003, the GAVI Secretariat had a total staff of 12 staff (8 professionals and 4 general staff) plus 4 short term staff, with a bias to higher grades than the Stop TB Partnership Secretariat. Most fund-raising is done by a separate entity, the Vaccine Fund, though the GAVI Executive Secretary plays a key role in resource mobilisation for the Alliance.

235. By comparison, a GFATM discussion paper on governance in October 2001 argued that the GFATM should be adequately resourced for its wide range of responsibilities, and not be in a position where it had to beg for resources or place over-reliance on voluntary inputs from already overstretched staff in the technical agencies. It concluded therefore that the Secretariat should be core funded with the possibility of voluntary inputs, including secondments from key stakeholders, at the margin. The GFATM Transitional Working Group subsequently approved Secretariat strength of 12-15 professional staff, with associated support staff. By October 2003 the GFATM had a Secretariat of 74 staff.

236. The McKinsey evaluation earlier this year covered staffing issues in the GDF, recommending that it was significantly understaffed to meet proposed plans. Its future staffing needs will depend on the Board's strategic decisions on the future of the GDF.

237. The rest of the Secretariat deals with partnership support and innovation, advocacy and communications, and general management and administration. Workloads are reasonable except at the most senior levels, notably the Executive Secretary and the Support and Innovation team leader where structural solutions rather than more staff are recommended (see below). Detailed discussions with the Executive Secretary suggest there is some limited scope for staff savings. One P5 position will be dropped when a secondment ends in December 2003. A secretarial vacancy should not be filled. There may also be advantage in reshaping general staff functions, to reduce the number of pure secretarial positions retained (where there appears to be some under loading) and provide more administrative support. Consideration is being given to the continuing need for dedicated capacity in the Secretariat on social mobilisation. This report has recommended elsewhere that the technical partners (i.e. IUATLD, WHO, KNCV) should give a higher priority to social mobilisation activities.

238. Additional identified staffing needs in the rest of the Secretariat include capacity for intensified work on advocacy and communications and on resource mobilisation. This evaluation concludes that these needs can be met within the current staff complement – if positions are filled and appropriately deployed. The current complement for advocacy and communications of three professional staff (one P5 and two P4, excluding a current additional P2 to assist with the Partners' Forum) plus two G4 staff should be sufficient for the Secretariat's expanded role, if vacancies are filled suitably. There will also need to be an appropriate budget to contract in specific professional advice, as necessary.

239. A P5 appointment is currently being made to a joint resource mobilisation and financial management position. Given the different skill-sets involved, it is unlikely that both these areas can adequately be covered by recruitment of a single person. In addition, effective support for resource mobilisation for the Partnership will demand a full-time commitment. It is therefore recommended that there should be two positions, one for resource mobilisation and one for Secretariat financial management, human resources and administrative matters (see below for more details). These positions can be accommodated without expanding the current staff complement.

240. The estimate of Stop TB Partnership Secretariat staffing costs for 2004 is \$3.48 million. Two posts – the Executive Secretary and his secretary – are funded from the WHO's regular budget. In kind support is being provided by the Netherlands Government and Management Sciences for Health to meet the costs of Secretariat staff, with the balance met through WHO's extrabudgetary funds²⁴.

²⁴ 2004 staff costs breakdown: \$237,000 from WHO regular budget, \$160,000 each from Netherlands and MSH and \$2.92m from WHO extrabudgetary sources.

Secondments

241. Currently four out of 23 professional positions in the whole of the Secretariat are filled by secondees from partners: the American Thoracic Society (ATS), the Dutch Ministry of Foreign Affairs, Management Sciences for Health and Partners in Health, Harvard Medical School. A second secondee from Management Sciences for Health left the Secretariat in June 2003. This flow of secondees to the Secretariat is fundamental to the original concept of the partnership, and to providing the range of expertise and experience required to support it. Continued, indeed enhanced, support – in the form of individuals or funding for secondments - is required from a wider range of partners. If the full benefit of secondments is to be achieved, Secretariat managers must pay more attention to ensuring a good fit between secondee and job description, and to integrating newcomers into the teams. This point also applies to direct WHO recruits to the Secretariat.

242. Conversely the Partnership Secretariat funds 50% of a secondee to the World Bank. All concerned feel this arrangement works well and to mutual benefit. The Secretariat has expressed interest in adopting this model with selected other partners. This certainly has potential, provided that the jobs are well-designed and effective working links established. Nonetheless, it will be important to retain a core of Secretariat staff working together in one place to ensure overall cohesiveness.

Contracts, turnover, vacancies and recruitment processes

Contracts

243. Secretariat staff are WHO employees or secondees to WHO. Of the total full-time equivalent, only 6.55 secretariat staff (20%) are on WHO fixed-term contracts, which are time-limited but open to extension without break. For example, the Executive Secretary post was advertised as a two-year appointment. The remaining 27 staff are temporary appointments, mostly for 11 months but two for 5 months. Their conditions are significantly less good in terms of entitlements and staff development. Contract extensions may be offered up to a maximum of 44 months in four years. Action is currently in hand to convert three temporary appointments for key Secretariat staff into fixed term. This will result in 28% of Secretariat staff being fixed-term. By comparison, 78% of the GFATM's staff (58 out of 74) are permanent.

244. The consequences of this predominantly temporary profile of staff include a notable sense of insecurity (especially among general grade staff) and serious disruption of work, given the WHO requirement for contract breaks of up to 30 days between short-term contracts for temporary appointments. Some of the Secretariat's most senior staff are subject to contract breaks. Timing of the breaks can be a problem in relation to work priorities. The contracts of 21 staff will expire in the next twelve months, most of which will be renewed. In moving from start-up to sustainable operations, the Secretariat needs to focus on increasing the ratio of fixed term to short-term positions.

Turnover

245. Over the last twelve months, turnover has been extremely high at 35%. This represents a huge burden in terms of disruption of Secretariat activities, loss of institutional memory, wastage of individual induction and development, and transaction costs for exits and recruitments. Handling this level of turnover, and constantly renewing short-term contracts, has strained the capacity not only of the Secretariat but also of the WHO Management Services Unit which provides HR support.

246. Factors fuelling turnover over and above normal career development appear to include individual insecurity over temporary appointments, inappropriate appointments, making poor use of staff and too little emphasis on people management and development.

Vacancies and recruitment processes

247. At present the Secretariat has eight vacancies (24% of complement). This inevitably puts pressure on the remaining staff. The GDF is particularly low on staff in position (29% of the full complement are vacant – 4 positions, including the GDF Manager).

248. The Secretariat has expressed considerable concern about the effort and time taken to complete WHO recruitment processes. A summary of time taken for vacancies / appointments over the last twelve months is given in Annex F. Analysis of short-term appointments in the last 6 months suggests that the appointment of new recruits has taken an average of nine weeks in total. This does not seem unreasonable for an employer with fair and open recruitment policies. However, some appointments have taken substantially longer.

249. There have been serious delays in recruiting to fixed term positions. The recent appointment of the Executive Secretary, using the post description of his predecessor, took the shortest time at 25 weeks. A Finance Officer recruitment, which was notified in November 2002 and approved by WHO's Director General in December 2002, has still not been finalised in November 2003. The Management Services Unit advises that delays can typically occur at the stages of classifying the grading of the post, creating the post in WHO's Central Budget and even in translation for the advertisement.

Staff Skills and Management

250. The GDF evaluation noted that the GDF's management team had largely met expectations, and that the success of the GDF was widely credited to the team's dynamism, innovation, "can-do" spirit, and strong and technically competent leadership. It also noted that the team was relatively young, had limited "business" experience and lacked skills in key areas of marketing/brand-building, fund-raising, monitoring and evaluation, and developing management systems.

251. This evaluation has drawn broadly similar conclusions in relation to the rest of the Secretariat.

252. Its management team has been instrumental in many of the Partnership's achievements to date. In particular, interviewees paid tribute to the skill, energy and sensitivity of Dr Jacob Kumaresan who was Executive Secretary until earlier this year.

253. The moves in the last few months of the Executive Secretary, the GDF Manager and the WHO Stop TB Director mean this has been an exceptional time to review the Secretariat. Given this instability, it is not surprising to find an expressed need for clear and effective leadership, a more strategic approach to the work with strategies driving priorities, workplans and budgets, stronger management and decision-taking, and better communications within the Secretariat. These are key issues to be addressed by the new Executive Secretary, Dr Espinal, in close cooperation with the Board.

254. The Secretariat is relatively strong on technical TB skills. However, the issues of wider skill-sets and managerial systems noted by McKinsey in relation to the GDF apply largely to the Secretariat generally:

- the Secretariat like the Board needs to be more business-like. Building a business mindset for decision-making and operations, and providing effective man-management,

will require the development/recruitment of enhanced management skills, particularly at team leader level. Support in defining job descriptions appropriately and selecting suitable recruits with a balance of managerial experience would be provided by a proposed new senior Finance and Administration Officer. In the short-term, assistance should be sought outside the Secretariat

- key areas of Secretariat activity, notably planning/performance management and resource mobilisation, need to be professionalised. Given the different skill-sets involved, it is unlikely that these needs can be met by recruitment of a single Partnership Resource Administrator, as noted above
- advocacy and communications expertise needs to be further strengthened

255. Achieving these ends is likely to require both:

- continuing development of key staff in post and
- recruitment, as vacancies arise, of individuals with the requisite skills and expertise, including managerial skills

256. WHO's Personnel Management and Development System (PMDS), properly used, provides Secretariat line managers with a framework for relating individual to organisational objectives, providing systematic feedback on performance (including areas of weakness as well as strength), and agreeing training and development goals.

Secretariat Structure

257. The incoming Executive Secretary should review the current structure of the Secretariat staffing. The post description indicates that 13 professional grade positions²⁵ should report directly to him. While flat teams are not uncommon in groupings of professionals, this structure imposes an unmanageable burden on a postholder who has major responsibilities for partnership-building and working with Stop TB partners of all kinds around the world. He has a clear role in providing leadership and oversight of the Secretariat. But he also needs to be supported by a strong internal management structure to free more of his attention for his external functions.

258. The Executive Secretary is accountable for the performance of the Secretariat. He should be free to organise his staff as he thinks best. The evaluation team is less concerned about the precise structure than the principle that it must be sufficiently powerful to handle the bulk of internal operational issues without involving the Executive Secretary in detail, in order to allow him to play his part in the wider Partnership. He will frequently be away from the office.

259. Over the medium term, the balance of the Secretariat's work may change, not least depending on decisions on the GDF. To meet immediate needs, the evaluation suggests that the Secretariat should revert to three teams below the Executive Secretary: the GDF, Partnership/Support and Innovations, and Advocacy and Communications, each under its own experienced team leader. These team leaders must have the stature to carry credibility with partners, including WHO.

260. The recent interim Executive Secretary has run with two team leaders – one for the GDF and another for all other Secretariat functions. It is evident that the latter, while highly regarded, has been significantly overloaded and the current requirement to provide greater Secretariat support for advocacy and communications suggests a need for dedicated attention to this function.

²⁵ Source: post description to support the Executive Secretary vacancy notice

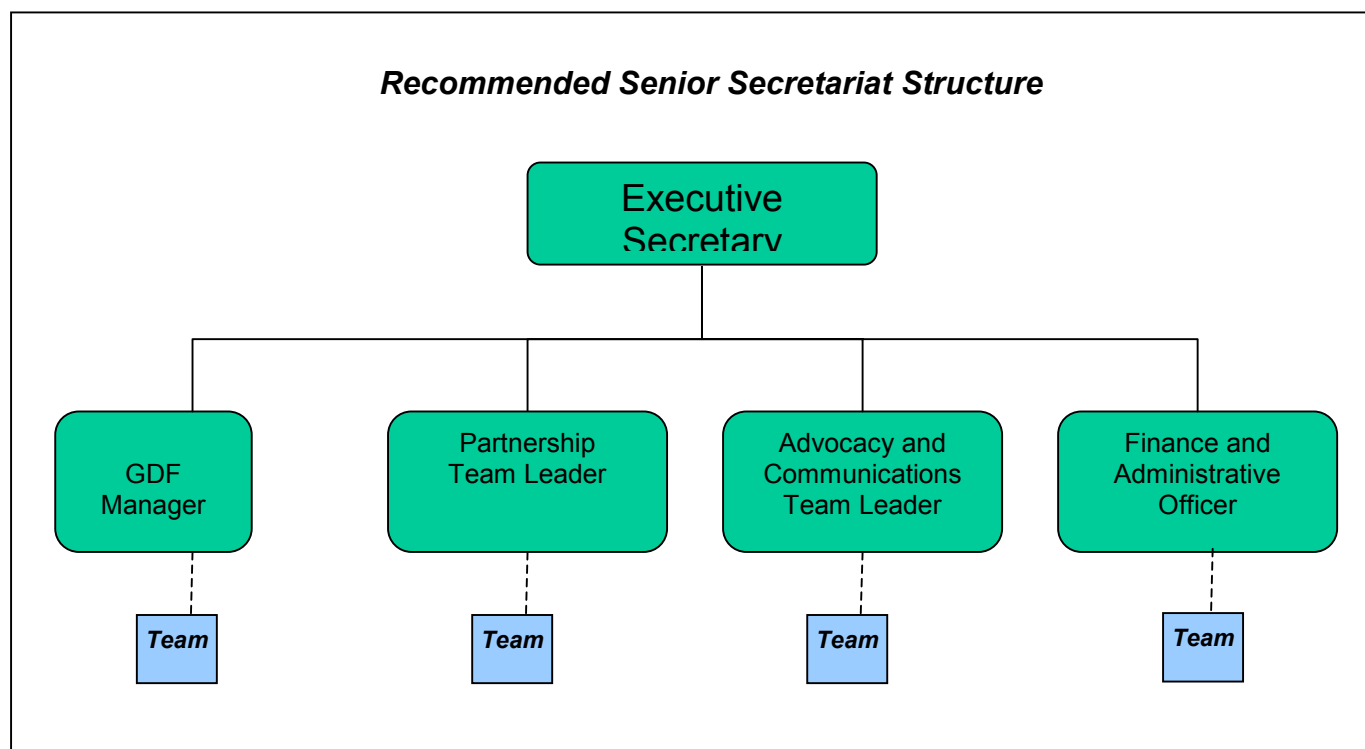
261. An additional option might be the insertion of a Deputy to take responsibility across either the full span of control or for selected teams (eg those for Partnership/Support and Innovations and for Advocacy and Communications, leaving the GDF manager to report direct to the Executive Secretary). While this is practicable and would assist in freeing up the Executive Secretary further, the balance of merit probably favours fostering a cohesive unit by retaining direct relations between the teams and the Executive Secretary. Effective mainstreaming of advocacy and communications issues across the whole Secretariat will be particularly important.

262. A key issue for decision by the Board and Executive Secretary is whether the GDF should develop its own separate infrastructure (eg for advocacy and administration) or whether in the interests of efficiency and coordination, high-level expertise of this kind should operate across the whole of the Secretariat.

263. This decision will be influenced by the Board's forthcoming decisions on the future strategy for the GDF and WHO's decisions on other GDF mechanisms. Subject to those decisions, the evaluation team's recommendation is for an integrated approach, with clear accountabilities.

264. Consideration should be given to establishing a senior Finance and Administration Officer position for the Secretariat as a whole. The aim is to ensure the effective management of financial and human resource issues across the Secretariat (including the GDF) and relieve its technical staff – and indeed the Director of Stop TB - of their current substantial involvement with detailed administrative issues, over and above necessary engagement on points of principle. The postholder should be well acquainted with WHO rules, regulations and procedures and work in close liaison with WHO central administration in the best interests of the Partnership. This position would be offset by savings of one more junior position, and time of senior Secretariat staff.

265. There should be a separate position for resource mobilisation. This recommendation cuts across the appointment currently being made to a joint resource mobilisation and financial management position.



Key findings and recommendations

266. The Secretariat's functions are broadly appropriate, subject to incorporating in the Basic Framework definition a greater emphasis on resource mobilisation, advocacy and communications, and on accountability mechanisms. The development of strategies for resource mobilisation, advocacy and communication must be underpinned by a clear delineation of the respective roles and responsibilities of the Board, of any relevant Working Group or Task Force and of the Secretariat.

267. The function specified in the Basic Framework in relation to coordination should be clarified. An alternative wording of the function might be "to support the Board in coordinating and monitoring activities of Partnership bodies, in pursuit of Partnership targets".

268. Board members look to the Secretariat to play an activist role in shaping strategies, securing consensus and implementing initiatives. The scope for any greater delegation of formal authority should be considered by the Board in the context of considering delegation of authority to an Executive Committee.

269. The evaluation endorses the Board's decision that the GDF, which is managed in tandem with the Green Light Committee, should continue to function as part of the Partnership Secretariat and to report to the Executive Secretary. Filling the vacant GDF manager position with a suitably experienced candidate is an immediate priority.

270. The location of the Secretariat in WHO benefits both parties, despite the administrative frustrations encountered. Technical relationships are strong, without compromising the Partnership's independence. WHO has played a relatively hands-off and constructive role in governance. Preliminary analysis suggests that its Programme Support Charge broadly offsets indirect costs incurred in hosting the Secretariat and that WHO makes a substantial net contribution to the Partnership. However outstanding legal and administrative difficulties now need to be resolved, including signing of a general MOU between the Partnership and WHO to reinforce provisions in the Basic Framework, and a renewal of the specific MOU for the GDF if separate MOUs are required.

271. The innovative process used recently to appoint a new Partnership Executive Secretary could be a model for other Partnerships housed in WHO.

272. Ideally the Executive Secretary of the Stop TB Partnership should report to the Chair of the Partnership's Coordinating Board as representative of the whole Board. However, on current WHO advice, the Executive Secretary of the Stop TB Partnership must, under the guidance of the Stop TB Coordinating Board, report formally to the WHO Director of Stop TB, so long as s/he is a WHO employee. This position should be reconsidered if a different outcome is adopted in relation to the RBM Executive Secretary as the posts are analogous.

273. There should be an early review of the grading of the post of Stop TB Partnership Executive Secretary, with a view to upgrading to D1 as a minimum (or D2 if that is the grading confirmed for the post of RBM Executive Secretary with its broadly analogous responsibilities).

274. Staff in the Secretariat are deeply committed to the mission to Stop TB. After a difficult period involving loss of key staff and serious funding challenges, the Secretariat urgently needs clear and effective leadership, a more strategic approach, stronger management and decision-taking, and better internal communications. These are key issues to be addressed by the new Executive Secretary, in close cooperation with the Board.

275. The summary picture of Secretariat human resources is that staff numbers may be a little too high, grades too low, contracts too uncertain and turnover too rapid. A comprehensive human resources strategy for the Secretariat should be developed as a matter of urgency, in concert with WHO's HRS and the MSU. It should address forecast staffing requirements, taking account of numbers, experience and skillsets, and succession planning; staffing structure; action to reduce exceptionally high turnover rates (35% over the last 12 months); and appraisal and development.

276. The GDF's staffing needs (against a current staff of 14) will depend on the Board's forthcoming strategic decisions on the future of the GDF. Detailed discussions with the Executive Secretary suggest there is some limited scope for staff savings (say, three positions) in the rest of the Secretariat. Projected staffing needs, including intensified support for advocacy, administration and resource mobilisation but reduced support for social mobilisation, can be met with the remaining staff positions, if filled and appropriately deployed. There may also be advantage in reshaping general staff functions, to reduce the number of pure secretarial positions retained (where there appears to be some under loading) and provide more administrative support.

277. There is urgent need to shift the balance away from so great a reliance on temporary staff (80% of staff) and to fill more positions with fixed term staff to provide a central core for the Secretariat. This is critical at team leader level, but selected fixed term appointments at all grades, including secretaries, are important to the efficient and effective conduct of business.

278. To free more of the Executive Secretary's attention for his external functions, he should be supported by a strong management structure within the Secretariat. The obvious immediate option would be three team leaders for Partnership/Support and Innovations, the GDF and Advocacy and Communications, plus a new senior Finance and Administration Officer position to ensure the effective management of financial and human resources across the Secretariat (including the GDF).

279. The Secretariat is relatively strong on technical TB skills but there is need to develop a more managerial culture and strengthen expertise in advocacy and communications, resource mobilisation and planning/performance management. Achieving these ends is likely to require both continuing development of key staff in post and recruitment, as vacancies arise, of individuals with the requisite skills and expertise, including managerial skills.

280. Some critical issues in the HR strategy will require agreement with the MSU or WHO's central HRS. To reduce system delays and capacity constraints, the Polio Eradication Initiative has worked closely with its MSU, providing funding for personnel and undertaking more of the functions itself. It has negotiated a reduction of the contract break to two weeks for some key staff, and has also developed strategies to speed up the system of converting short term to fixed term posts. The Stop TB Partnership and its MSU need to adopt a similar approach, working together to find ways to reduce delays and negotiate flexibilities for core Secretariat staff. WHO has indicated that, while there is scope for some flexibility, it will wish to see the principle of geographical and gender representation respected. This principle is fully supported by the evaluation team. It is appreciated that this will be a time-consuming process on both sides.

281. Accepting the need for due process, WHO should take urgent steps to reduce the unjustifiable delay in processing fixed-term recruitments – not just for the Partnership Secretariat but for the whole of HQ, if the Secretariat's experience is typical. Equally, the Stop TB Partnership Secretariat need to ensure that systems are in place to ensure that the relevant paper work and applications are entered into the system and followed up.

VI: PARTNERSHIP PROCESSES – A MORE OPEN AND BUSINESS-LIKE APPROACH

General

282. Two general themes recurring in evaluation interviews are the need for the Partnership to become more business-like as it moves out of start-up phase, and a strong desire for transparency and openness. The two may well be inter-related. This section considers process issues, with particular reference to Board processes and to performance and financial management.

Board processes and decision-making protocols

The Basic Framework

283. The Partnership's Basic Framework specifies eight requirements for the Board's operation, three relating to its officers and five to its operations.

Basic Framework provisions for Board officers

- *The Board will select from among its members a Chair whose term will be two years renewable. However, the Chair shall not serve more than two consecutive terms*
- *At each session, the Board shall elect a Vice-Chairman, and as many rapporteurs as needed, from among its members*
- *The Executive Secretary will act as the Secretary of the Board*

Framework provision: The Board will select from among its members a Chair whose term will be two years renewable. However, the Chair shall not serve more than two consecutive terms.

284. The term of the first Chair, Dr Ernest Loevinsohn of CIDA, ended at the last Board meeting on October 2003. The Basic Framework does not specify the process for selection of the Chair. During evaluation interviews as recently as a month before the meeting, Board members advised that they had had no indication of what steps were to be taken in relation to the Chairmanship.

285. In the event, the Working Committee eventually initiated a selection process for the Chair which was further elaborated by a Nominating Committee and resulted in the reappointment of Dr Loevinsohn until October 2005. Broadly both the process and the criteria for selection of the Chair seem to have been acceptable to Board members, subject to beginning the process earlier to allow Board members unavoidably unable to attend the Board meeting to contribute.

286. It is recommended that:

- in the interest of trust and confidence among partners, the Board should now agree a full set of processes for electing Board officers. It is noted that, as a complement, a helpful process for the selection of the Executive Secretary was established earlier this year
- the Board approves the following principles and process for electing the Chair of the Coordinating Board:

Recommended Process for Selecting the Chair of the Coordinating Board

- *The Board will select from among its members a Chair whose term will be two years renewable. However, no individual shall serve as Chair for more than two consecutive terms.*
- *The criteria for eligibility for Chair will include:*
 - *membership of the Coordinating Board*
 - *a willingness to fulfil the commitments of the Chair, including its representative role, and to devote time and effort to enhance the Partnership*
 - *good oral and written communication skills, including fluency in English*
 - *a willingness to provide support and access to the Secretariat*
- *An Autumn Board meeting shall be organised to coincide with the expiry of the Chair's term.*
- *At the Spring Board meeting before the Autumn Board meeting when the Chair's term is to expire, the Board shall appoint a Nominating Committee of three Board members who do not themselves intend to stand for the Chairmanship. In advance of that Spring meeting, the Executive Secretary will issue an invitation for volunteers to serve on the Nominating Committee.*
- *At least three months before the expiry of the Chair's term and the Autumn meeting, the Nominating Committee will invite Board members to notify them of nominations for the Chair by a given date.*
- *The Nominating Committee will scrutinise the nominations to determine eligibility, then contact eligible nominees to determine their willingness to stand.*
- *At least six weeks before the expiry of the Chair's term and the Autumn meeting, the Nominating Committee will advise Board members of the actual candidates. In the event of more than one candidate, the Committee will announce a vote to select a Chair, on the basis of one vote for each Board member. The vote will be conducted anonymously and will take place at the Autumn Board meeting. Board members unavoidably unable to attend may notify the Nominating Committee in writing of their vote, provided that they are prepared to accept that their vote will not be anonymous and that the vote is received in advance of the Board meeting.*
- *At the Autumn Board meeting, the Nominating Committee will oversee the voting process, provide facilitation as necessary and advise the Board of the outcome of the selection. The Board will formally approve the Chair.*

Framework provision: At each session, the Board shall elect a Vice-Chairman, and as many rapporteurs as needed, from among its members

287. In practice, the Board has been operating with a constant Vice-Chair, Professor Francis Omaswa, Director-General of Health Services, Uganda. At the Coordinating Board in October 2003, the Nominating Committee for the Chair made a number of proposals for electing a Vice-Chair. Building on those proposals, it is recommended that the Board approves the following principles and process:

Recommended Process for Electing the Vice-Chair of the Coordinating Board

- *The Board will elect from among its members a Vice-Chair whose term will be two years renewable. However, no individual shall serve as Vice-Chair for more than two consecutive terms.*
- *The Vice-Chair will be elected in the alternate years between the election of the Chair, in the interests of continuity.*
- *Appointment as Vice-Chair will carry no implications in relation to future chairmanship of the Board.*
- *The function of the Vice-Chair will be to chair sessions of Board meetings, (or, if the Board establishes an Executive Committee, Executive Committee meetings) in agreement with the Chair; and to represent the Board in meetings and missions.*
- *The process for nomination and election of the Vice-Chair will follow that for the selection of the Chair.*

288. The Nominating Committee also proposed that balance should be sought in developing/ developed country representation between Chair and Vice Chair. The evaluation endorses the broad principle, subject to the consequences of staggering of terms and the need to avoid locking either grouping into a particular role.

289. Following the Board's consideration of these recommendations, it should agree the process for electing its Chair and Vice-Chair and make it publicly available on the Stop TB partnership website along with a suitably revised Basic Framework.

290. As in the Basic Framework, the Board will elect any rapporteurs needed at a given session from among its members in attendance.

Framework provision: The Executive Secretary will act as the Secretary of the Board

291. The Executive Secretary, as Secretary of the Board, is responsible for the preparation of the draft agenda and the report of the session. S/he should also have responsibility for overseeing follow-up action on decisions and directives of the Board and reporting progress to the Board. This important role should be reflected in any future revision of the post description.

Basic Framework provisions for Board operations

- *The Board shall meet at least twice a year, with provision for electronic conferencing where rapid decisions are needed.*
- *To the maximum extent possible, the decisions of the Board are taken by consensus.*
- *The decisions of the Board are not considered as binding upon the partner organizations and will not override their respective governing bodies.*
- *The provisional agenda of the session will be prepared by the Executive Secretary in consultation with the Chair.*
- *The report of the session, prepared by the Secretary, will be circulated as soon as possible.*

Framework provision: The Board must meet at least twice a year, with provision for electronic conferencing where rapid decisions are needed

292. Since its establishment in 2001, there have been two Board meetings per year - one interim and five formal – and occasional teleconferences.

293. The Board is struggling to handle the volume of business on this basis. For example, given the current conjunction of a number of strategic issues and pressure of work-planning activities, the Board had planned to hold a third Board meeting in 2003, in tandem with the 2003 Partners' Forum until the latter was postponed. It has now substituted a teleconference though this cannot deal adequately with the range of items originally intended for the December Board meeting.

294. At the same time, Board members – who serve voluntarily in addition to their own substantive jobs - have expressed concern about the total demands on their time, including two or three day Board meetings plus travel time, the Partners' Forum, missions to countries etc. This precludes a routine move to more than two Board meetings per year.

295. This evaluation has therefore recommended in section III the establishment of an Executive Committee to relieve the load on the full Board and allow it to focus on priority strategic issues.

Framework provision: To the maximum extent possible, the decisions of the Board are taken by consensus

296. Seeking decision-making by consensus to the greatest possible extent is fundamental to the spirit of a partnership. Nonetheless, it might be advisable to have an agreed process as a last resort, if consensus is not achievable. Both the GFATM and GAVI have provisions for voting. In practice, the Stop TB Partnership Board already uses voting on an informal basis. It is recommended that the Basic Framework should be amended as follows:

“to the maximum extent possible, the decisions of the Board are to be taken by consensus. As a last resort, where a clear decision is required and consensus is not achievable, the Board will vote on the issue on the basis of one vote for each Board member in attendance. The decision will rest on a simple majority. There will be no powers of veto”.

297. It has been suggested that this might pose some difficulties for WHO, but it should be noted that the WHO Director General sits on the GAVI Board which has a similar voting clause.

Framework provision: The decisions of the Board are not considered as binding upon the partner organizations and will not override their respective governing bodies

298. A fundamental operating principle of the Partnership is therefore the dependence on each partner and constituency to seek to ensure the consistency of the policies and decisions of their individual organizations with those of the Partnership. The report of the Bellagio Interim Coordinating Board meeting records that policy decisions made by the Board will be respected by WHO. The authority of the Board derives from the trust invested in it by the Partners. This approach seems to have operated satisfactorily.

Framework provision: The provisional agenda of the session will be prepared by the Executive Secretary in consultation with the Chair

299. In practice, provisional agendas for Board meetings and teleconferences are prepared by the Executive Secretary/Secretariat and considered by the Working Committee, which includes the Chair. If the recommendation above for an Executive Committee is adopted, Executive Secretary/Secretariat should consult that Committee which will include the Chair. In the interests of flexibility, the Basic Framework should continue to refer to consultation with the Chair while the full Working or Executive Committee should routinely be consulted. However, it is recommended that the Basic Framework be amended to make explicit that each of the recognised constituencies may raise issues for consideration by the Board, either through the Secretariat or through their representative on the Board.

Framework provision: The report of the session, prepared by the Secretary, will be circulated as soon as possible

300. At the Board meeting of October 2003, the Secretariat circulated a summary note of decisions and action points at the end of the meeting, in advance of the formal report which should be circulated in draft form within two weeks of the meeting.

301. Recommendations

- The Board should agree and make available on the partnership website a full set of processes for the election of Board officers. This report makes detailed recommendations for the election of the Chair and the Vice-Chair, drawing on the experience of selecting a Chair in October 2003.

- The Basic Framework should be amended to specify that the Vice-Chair should be elected to serve a two-year term, rather than for each session. No individual should serve more than two consecutive terms.
- The Basic Framework should be amended to specify voting on a one member, one vote basis as a last resort, if consensus proves unachievable.
- The Basic Framework should also be amended to make explicit that each of the recognised constituencies may raise issues for consideration by the Board, either through the Secretariat or through their representative on the Board.

Board conduct of business

302. The McKinsey evaluation of the GDF concluded that the Coordinating Board was relatively well-functioning, with balanced representation, a collaborative working style and a focus on getting things done. It found, however, a limited sense of responsibility among the Board and its Working Committee for the GDF.

303. Observation of the Board during this evaluation also suggests that business is conducted reasonably well for the Board's large size and Board interactions are good. Contributions were high-quality and focused on the issues; almost all Board members were engaged on every issue; and differing views were expressed without abrasiveness. A reality check was provided by strong contributions from members from countries. There were clear process rules, sensitively enforced: ten-minute presentations, orderly management of speakers; tightly chaired items; and a clear summary of the outcome by the Chair/Vice Chair allowing members to comment, if minded, and ensuring the formal report should contain no surprises.

304. Nonetheless, there is scope for improvement. Incisive decision-making and systematic progress chasing of follow-up are critical. There is a perception that certain issues are regularly afforded more Board attention than others. Despite Working Group Chairs being Board members, most Working Groups (and particularly the New Tools Working Groups) tend to feel that the Board is not sufficiently engaged with their issues. This concern about the balance of the agenda should be addressed to some extent by earlier recommendations about a greater focus on all Working Groups and provision for constituencies to raise issues for the Board's consideration.

305. At the Board meeting observed during the evaluation, the agenda was very heavy, in both the number and the substantiveness of the items. There seemed a marked preference for an oral approach, to the extent that there were no papers for some items - even relatively complex and/or controversial ones (e.g. social franchising and the GDF).

306. The consequences are that members have limited opportunity to assimilate issues in advance and develop contributions and queries; details are at risk of being overlooked; and members unavoidably not attending cannot send in comments. It may also explain in part a feeling among some non-Board members about the opacity of the Board. In effect, details may be available only to those in attendance since meeting reports tend to be summary and action-oriented.

307. This feeling is reinforced by the fact that until this evaluation, notes of Board and Working Committee meetings, together with Board papers, have been posted on the secure pass-worded Board section of the Stop TB Partnership website. Open and effective communications are critical to trust in a dispersed partnership, and there is a clear call for easier access to information.

308. Without becoming bureaucratic or stifling spontaneity, the Board should have a concise paper (ideally no more than two pages) for each substantive item with key facts (including resource implications if relevant), issues, options and, wherever appropriate, recommendations. The first page should highlight a brief précis of the issues, the recommendations and the action required of the Board, on the GAVI model (example at Annex G).

309. In principle, the deadline for Board papers is four weeks before the meeting. Most papers are resent electronically ten days before the meeting and given to Board members in hard copy on arrival at the meeting. In practice at the October 2003, too much important information was tabled. Board members should receive all Board papers at least ten days before the meeting. This is important to allow members time to reflect and consult, and provide written comments if unable to attend.

310. As a matter of effective oversight, the Board should also check progress on past Board decisions. The Secretariat is already preparing a log of Board decisions.

311. Recommendations

- For each substantive Board meeting item, Board members should be provided with a concise paper giving key facts (including resource implications if relevant), issues, options and, wherever appropriate, recommendations.
- The Board has already agreed at its October meeting that the first page should highlight a brief précis of the issues, the recommendations and the action required of the Board (example at Annex G).
- Board members should receive all Board papers at least ten days before the meeting.
- The Board has already accepted the evaluation team's recommendation that all Coordinating Board papers and agreed reports of meetings and teleconferences should be accessible to partners and the general public on the open website, apart from coverage of exceptional confidential issues, eg relating to commercial/contractual or personnel issues.
- The Secretariat should provide a brief written progress report on past Board decisions for each Board meeting.
- All substantive Partnership meetings should be documented and the notes made available on the website.

Performance and Financial Management

312. There is scope for improving performance and financial management, and for reporting on these issues to the Board and partners. Some steps are already in hand, and the evaluation makes further recommendations.

Reporting on Partnership Workplans and Budgets

313. The Secretariat is responsible for developing its annual workplan and budget; it is now moving to a biennial workplan in line with WHO practice. The Secretariat work plan and budget are approved by the Coordinating Board. At the October 2001 Washington Coordinating Board meeting, the Board requested greater clarity on sources of funding, presentation of the workplan and the size of the budget. They also requested that the budget

set out in the Secretariat workplan should be consistent with the figure included in the Global Plan. The report on the subsequent Cape Town Board meeting suggested that the 2003 Secretariat workplan was much improved describing it as “detailed, transparent and accountable”. Nonetheless, evaluation interviews highlighted a current demand for a more open and a more business-like approach, particularly in relation to performance and financial management reports.

314. Currently Board members receive a number of reports which map progress against the workplan:

- a narrative progress report on Secretariat activities outlining key activity highlights during the period between Board meetings (at every Board meeting)
- a more detailed annual activity annex outlining progress against specific activities outlined in the Secretariat work plan
- an annual Financial Statement spelling out sources of funds (including in kind contributions) and utilisation of funds according to broad components (GDF, Partnership, Advocacy and Communications and Administration). Separate statements are provided for the GDF and for all other Secretariat activities. The statement also presents a form of cash flow analysis (for the following year), comparisons between budgeted and actual expenditures, and estimates of planned activities and projected funding (and therefore shortfalls) during the current year. At the October 2003 Coordinating Board meeting, updated estimates were circulated as background information for discussion of the GDF

Financial management

Need for more realistic and flexible approaches to planning

315. At the Secretariat level, budget processes have lacked credibility. There have been wide differences between approved workplan budgets, income received and actual expenditure. For example, in 2002 actual Secretariat expenditure was some 56.8% of its approved budget. This has been due largely to shortfalls on the GDF side. As at 30 September 2003, less than 2% of the annual approved budget for GDF drug purchases had been spent, due to the lack of donor funding to enable a new contract to be signed with the procurement agents.

316. Agreement on a widely-owned Global Plan is undoubtedly a major success of the Partnership. However, the Plan is unusual in that it (rather heroically) presents specific budgets for a full five year period. Similarly the GDF’s Strategic Plan sets patient and financial targets for five years.

317. Coordinating Board meeting minutes suggest there has been pressure to ensure that annual budgets conform to these targets, regardless of experience or changing needs. As income has been well below that required to support such plans, the gap between budgets and actual expenditure has been large. Policy decisions, notably the approval of Technical Review Committee recommendations for new grants, have therefore been based on inappropriate estimates of available resources.

318. More realistic and flexible approaches to planning are required. Firstly, strategic plans have to be seen as broad frameworks. In a rapidly changing world, especially one where both funding and the timing and impact of new diagnostics, drugs and vaccines are all uncertain, a more flexible approach is essential. Secondly, while the Global Plan may continue to inform fund-raising targets, more account of realistic resource availability should be taken in developing operational workplans and budgets. These latter would provide the basis for monitoring and accountability.

More transparent classification of income and expenditure

319. The current approach has strengths. The incorporation of in kind support is a notable achievement and an areas which other Partnerships such as GAVI have faced major challenges.

320. However, the existing classification of income and expenditure is not particularly transparent. To date, the financial statements have provided information on a highly aggregated basis according to broad themes. The classifications have been further aggregated as part of the 2004/5 Workplan process as set out in the table below.

Key Classifications for Financial Reporting of Secretariat Activities

Key Themes	
2001 to 2003	2004/5
<ul style="list-style-type: none">• Partnership• Advocacy and Communication• GDF• Administration	<ul style="list-style-type: none">• Support and Innovation• GDF• General Management and Administration

321. Detailed information on income and expenditure from 2002 through to 2005 according to the new categorisation is provided in Annex H.

322. Without being drowned in detail, the Board needs more disaggregated information on what money is being spent on and how this relates to the Partnership's key objectives and outputs. The current WHO Activity Management System (AMS) is able to provide what the evaluation team feels is a more transparent picture of Secretariat operations and should be used in future as a basis for financial reporting. A suggested format is given in Annex N²⁶. In the past, all Secretariat funds have passed through the WHO AMS system with the exception of some in kind support. Now funds are also flowing through the Trust Fund. It is important that this fragmentation in funding flows does not obscure a comprehensive picture of expenditure. The 2004/5 work plan and subsequent work plans should therefore incorporate funding by source (WHO/Trust Fund/Other) according to the AMS expenditure classifications. This has not been done to date.

323. Recommendations

- Alongside a fund-raising budget, the Board should approve a realistic operational control budget for the Secretariat (including the GDF) which would provide the basis for activity implementation and for expenditure monitoring and accountability. In the event of significant changes of circumstances mid-budget, Board approval to a revision should be sought²⁷.
- The 2004/5 plan needs to set out proposed funding sources, both to ensure its realism and to ensure that the plan is not fragmented through the use of parallel funding mechanisms such as the Trust Fund.
- Financial reports should be amended to provide a more detailed outline of Secretariat spending based on AMS classifications, and incorporating all sources of funding.

²⁶ This would replace table 2 in the 2002 Financial Statement.

²⁷ The Board at its October 2003 meeting approved in principle a 2004/2005 "targeted Secretariat budget" as the fund-raising target, but without spending authorisation. An operational budget with realistic figures has since been approved by the Board.

- The next Global Plan should set out best estimates of projected financial needs but, within this, should introduce a rolling budget process in which the budget is agreed only for the first year with a process outlined for setting budgets in subsequent years.

Appropriate financing mechanisms

324. Considerable time and effort has been expended by Secretariat staff and the World Bank in establishing a Trust Fund to provide pooled funding to finance certain Partnership activities. The Fund is still not fully operational although it is understood that payments are now being processed. The goal of the Trust Fund is to promote the Partnership and strengthen it through the process of agreeing shared financial priorities. The issue of how to operate such a fund is being taken forward by a Board Trust Fund Task Force. It is being advised pro bono by a USA-based law firm familiar with World Bank and WHO operations and is currently considering options.

325. In theory, the Trust Fund could form the basis of a “SWAp type” approach in support of an agreed expenditure plan as set out in the Global Plan and annual Secretariat work plans. Over time it could become the major financing mechanism for Partnership activities. Such pooled arrangements could potentially reduce transaction costs, for example by promoting a shift towards a common reporting framework (though this could happen without the Trust Fund). At the same time the use of multiple funding channels runs the risk of reducing transparency.

326. Currently the operating principles of the Trust Fund imply heavy restrictions²⁸ on the use of the Trust Fund. If there were a realistic approved annual plan, such restrictions would serve little purpose and a more flexible approach would be warranted. In practice, at present there is no credible budget upon which to base such an arrangement. Furthermore, the Trust Fund is expected to account for only a small share of Partnership spending. It does not, therefore, in its present form appear to present an ideal vehicle for taking forward a pooled financing approach to developing closer partnership.

327. Whilst no attempt has been made to estimate the actual costs and benefits, it is likely that maintaining the Trust Fund will only make sense if:

- use of funds from the Fund are more flexible (provided that an agreed and realistic work plan is in place)
- steps are taken to ensure that planning approaches and financial management are not fragmented by the use of multiple funding channels

Better performance information

328. The progress reports provided to Board members are the key source of information on broad Partnership activities. Due to the large number of activities, they are not ideal but the nature of partnership is complex and it would be extremely difficult to boil performance down to one or two key indicators. It probably makes more sense to review progress towards partnership goals against a broad range of criteria as part of mid term reviews and evaluations rather than on a routine basis.

329. A number of Board members expressed concerns about lack of information on GDF performance, despite the fact that it accounts for the vast majority of Secretariat expenditure and its functions are generally more open to measurement. Whilst data on progress are reported to key donors (for example, the GDF provides a 6 monthly donor report), they have not been reported systematically to the Board or other key partners. Where data are

²⁸ It can only be accessed a limited number of times annually and only for certain purposes (partner planning and coordination, social mobilization and advocacy, training /research collaboration/dissemination and the contracting of procurement and quality control agents purchasing drugs on behalf of the GDF. There are expected to be 10-20 recipients each year and these will not include governments. Source: Principles for the Operation of the Stop TB Partnership Trust Fund October 2002

prepared, they are often not presented in a way which allows progress to be measured over time or measured against targets. For example, the donor report presents data only for the 6 month period in question or, for some indicators, cumulative data. Information is presented on delivery times without setting out the targets.

330. The review found that whilst there is no agreed list of performance indicators, information is being collected on a wide range of important variables such as the impact of DOTS coverage, additionality, lead times, errors in orders. If such data could be effectively packaged and regularly updated, it could more than adequately address these concerns.

331. Essentially two types of monitoring are required. Firstly, a succinct – maximum 2 page - report should be made available for the Board and for key donors. It should provide a balanced overview of performance, outlining performance against the GDF's own targets and against those of competitors where relevant. Such a report should highlight the introduction of new indicators which are only now becoming relevant - notably those related to the white list, monitoring and evaluation, and direct procurement. A possible format is at Annex K. The summary report should be updated for each Board meeting and posted on the website.

332. A more detailed monitoring system for internal management purposes should also be introduced; a format devised by the secretariat is attached at Annex L. This would be used to provide a comprehensive overview of progress against all key functions and although primarily for management purposes could be made available to the Board or donors on request.

333. Together the reports should provide a comprehensive picture of GDF performance, set out a clear interpretation of the results and also, where relevant, compare performance to those of competitors.

334. It is also important for the Board to disseminate key messages and synthesise key information on progress to the Partnership as a means of maintaining engagements with partners as well as bridging the gap between Partners' Fora.

335. Recommendations

- The Secretariat should strive towards producing a common performance management report for the Board and all donors which could be made available publicly, including on the website. This should provide information on expenditures (as outlined above), and trends in progress against an agreed set of performance indicators over time against targets.
- The Board should receive a specific summary report on the GDF (no more than two pages (Annex K)).
- A more detailed GDF monitoring report for internal management purposes should be introduced (Annex L).
- The Board should produce an annual report for the Partnership which would provide key performance management highlights along with effective advocacy material. Members may wish to form an ad hoc task force to identify the key contents of such a report.

Adopting a broader monitoring role

336. At present monitoring by the Board focuses primarily on Secretariat activities rather than on "partnership-related" activities such as the Working Groups, or even more broadly,

progress against the Global TB plan. There is a lack of clarity on where the partnership role ends²⁹.

337. For example, little financial information about the Working Groups has been available to the Board. The Groups have traditionally received little funding from the Partnership itself (although this is expected to increase). There is cooperation between donors supporting the Working Groups on the planning front (e.g. in coordinating visits or common training plans) but, whilst at least some of the Working Groups keep a track of spending informally, there is no formal reporting. In practice each donor tends to contribute its funds directly and account for its spending individually. While Working Group Chairs reported overall financing needs orally to the October Board meeting, the Board's locus and response was unclear.

338. At present the Secretariat has little leverage or capacity to take on this role as it provides little direct financial support to the Working Groups. Some interviewees strongly supported such shift and the need to move towards a results-based management approach to the Global Plan. Whilst the Board generally feels it is not in a position to oblige Working Groups to report on their spending, the failure to do so means that there is no real way of assessing overall Partnership funding or whether actual spending patterns reflect the priorities set out in the Global Plan. These issues could be picked up periodically as part of a global financing monitoring exercise (see below), but ideally such an approach would be integrated into an annual planning and budgeting cycle for all Partnership components. Some interviewees strongly supported such a shift and the need to move towards a results-based management approach to the Global Plan. The Board should seek the agreement of the Working Groups to adopt such practices. Modest amounts of Partnership funding for Working Group partnership activities could also support this process.

339. From a global financing perspective, WHO already collects some data on financing and financing gaps in its annual Global Tuberculosis Control: Surveillance, Planning and Financing report. It does not, however, present a comprehensive picture as it focuses largely on DOTS expansion. The key question is whether, and how, the Partnership might take on this role. A survey of spending is a major and costly effort and would not be feasible on an annual basis. However, it could be undertaken periodically – say, twice during the five year Global Plan cycle, once at its end and once as an input to a mid term review. This would significantly improve the knowledge base on trends in financing flows. The Secretariat has already drafted a framework which could be used as the basis for this type of analysis (Annex M).

340. Such a survey represents a significant piece of work so would need to be contracted out. Provision for this would need to be made in the Secretariat's annual workplan. In general, there would be both human and financial resource implications if the Board takes on a more systematic oversight role in relation to the Global Plan.

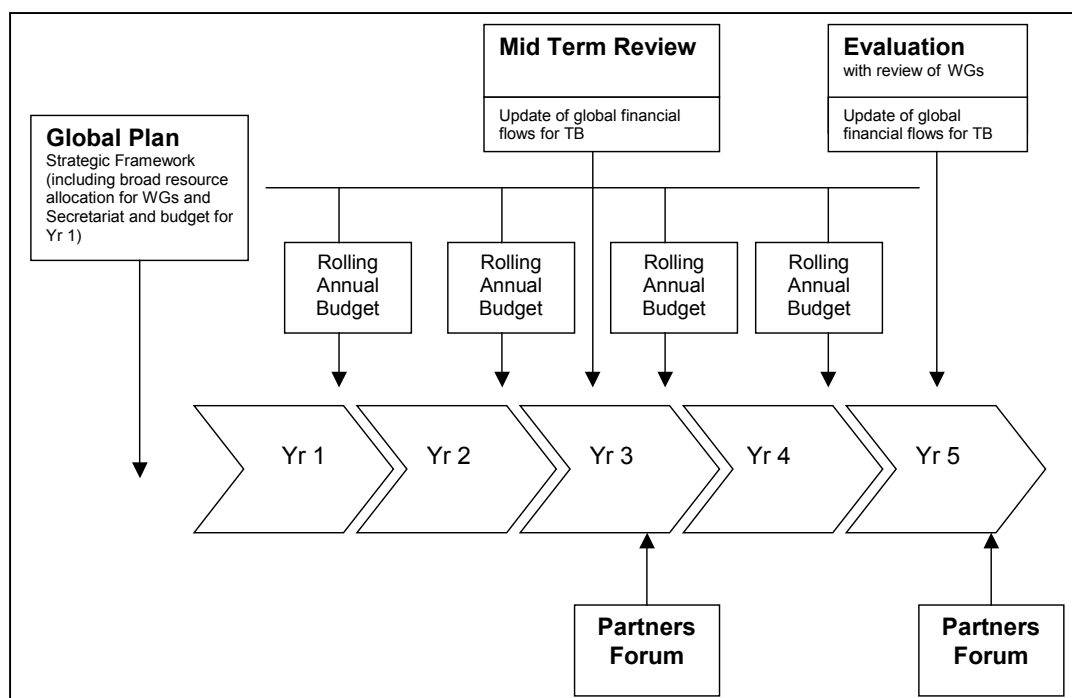
341. Taken together with earlier recommendations, this suggests a five-year cycle for the Global Plan (see overleaf), with:

- rolling annual plans/budgets/reports
- a mid-term review of progress supported by a survey of global financial flows for TB which would be reported to a Partners' Forum
- a final evaluation with an update of the global financial flows and a review of the need for Working Groups and Task Forces. This would provide the basis for preparation of the next five-year Global Plan which should be put for endorsement to the second Partners' Forum of the cycle

²⁹ This lack of clarity was apparent in a Working Committee teleconference where Working Group Chairs were unclear as to whether they should budget for the costs of the Working Group running costs only or broader implementation costs.

342. Recommendations

- The Board should develop a formal results-based management approach to monitoring progress against the Global Plan, with a mid-term review and end evaluation for each five-year cycle. In particular, it should seek the agreement of the Working Groups to annual financial and activity reporting on the understanding that the reports will be used effectively to assess collective progress towards targets.
- The Partnership should contract out a survey of global flows of funding for TB to feed into the next Global Plan. On the basis of that experience, the Board should consider introducing periodic monitoring of global funding flows, working in liaison with WHO to feed into subsequent mid term reviews and global plans. Particular emphasis should be placed on an analysis of existing GFATM grants.



VII: CONCLUSIONS

343. The Global Stop TB Partnership has established itself in a very short time as a widely respected global health partnership. In some quarters, it has been seen as the model partnership. The perception of partners themselves is that it has both added value to what they were already doing and moved swiftly to introduce new initiatives.

344. In terms of relevance and efficiency, it rates extremely high. On efficacy, the Partnership has scored some major achievements in only three years. It has built and is sustaining a broad network of partners; established a partnership architecture which commands broad support; heightened political commitment and marshalled widespread commitment to a detailed Global Plan to Stop TB; made significant progress against TB, even in difficult environments; highlighted work on new diagnostics, drugs and vaccines; and operationalised in a remarkably short time the Green Light Committee for second-line TB drugs and a complex Global Drug Facility covering grant-making, procurement and partner mobilisation for technical assistance for first-line drugs. This is a formidable record.

345. Strong commitment has been expressed by partners to sustaining the Global Stop TB Partnership. Its mission and strategy continue to command support, as it deserves. At the same time, the Partnership currently faces some challenges.

346. Only 16 countries have yet reached the World Health Assembly targets for 2005 which the Partnership has adopted. Much more will need to be done in actual implementation in affected countries, including those not considered high burden countries, if the targets are to be met on time. A report outlining progress, identifying constraints and making recommendations is currently with the Coordinating Board.

347. Changes in donor funding priorities and the establishment of new financing mechanisms such as the Global Fund to fight AIDS, TB and Malaria have intensified competition for limited resources and increased uncertainty over funding flows for the Partnership. The Partnership has recognised that advocacy and resource mobilisation needs to be handled more effectively, with the establishment of a proto Resource Mobilisation Task Force and new capacity in the Secretariat. Even so, the aim of secured long term financing of \$20-\$30m per annum starting from 2004 to sustain the Global Drug Facility in its present form does not appear realistic in current circumstances. If this is right, alternative courses of action are needed.

348. In general, global health partnerships of this kind raise sensitive institutional issues, balancing the need for inclusiveness and loosely-knit structures with a necessary minimum of business-like approaches and oversight. This tension has become more apparent in the Stop TB Partnership as the initial enthusiasm and compromises of start-up have given way to the accountability demands of sustainable operations commanding substantial resources. Two recurring themes in evaluation interviews have been the need for the Partnership to become more business-like and to operate with greater transparency and openness.

349. The Terms of Reference for this evaluation made clear that it was not a performance evaluation so much as an enquiry as to the optimal structure and function of the Partnership. The prime focus has therefore been on specific recommendations for improvements in governance, Partnership and secretariat structure, work-planning, financial management, human resource management and transparency in the conduct of Partnership business and information flow. The recommendations are listed in full in the final annex, Annex Q. They are designed to assist the Partnership as it moves forward to deliver its specific targets en route to its vision of a TB-free world.