



STOP TB PARTNERSHIP
EXTERNAL EVALUATION

5 JUNE 2015

FINAL REPORT

Submitted by:

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ACRONYMS AND ABBREVIATIONS

Acronym	Description
BRICS	Brazil, Russia, India, China and South Africa
CCM	Country Coordinating Mechanism
CDR	Case Detection Rate
CEPA	Cambridge Economic Policy Associates
CFCS	Challenge Facility for Civil Society
CIDA	Canadian International Development Agency
CSO	Civil Society Organisation
DFID	United Kingdom Department for International Development
DOTS	Directly Observed Treatment, Short-course
FLDs	First Line Drugs
GCTA	Global Coalition of TB Advocates
GDF	Global Drug Facility
GLI	Global Laboratory Initiative
HBC	High Burden Country
KPI	Key Performance Indicator
MDR-TB	Multi-Drug Resistant Tuberculosis
M&E	Monitoring and Evaluation
NFM	New Funding Model
NGO	Non-Governmental Organisation
NTP	National Tuberculosis Programme
PMNCH	Partnership for Maternal, Newborn and Child Health
PPM	Public-Private Mix
PSC	Programme Support Costs
RBM	Roll Back Malaria
R&D	Research and Development
SADC	Southern African Development Community
SIIC	Strategic Investment and Impact Committee
SLDs	Second Line Drugs
SOPs	Standard Operating Procedures
ToR	Terms of Reference
UNOPS	UN Office for Project Services
USAID	United States Agency for International Development
VfM	Value for Money
WHO	World Health Organization

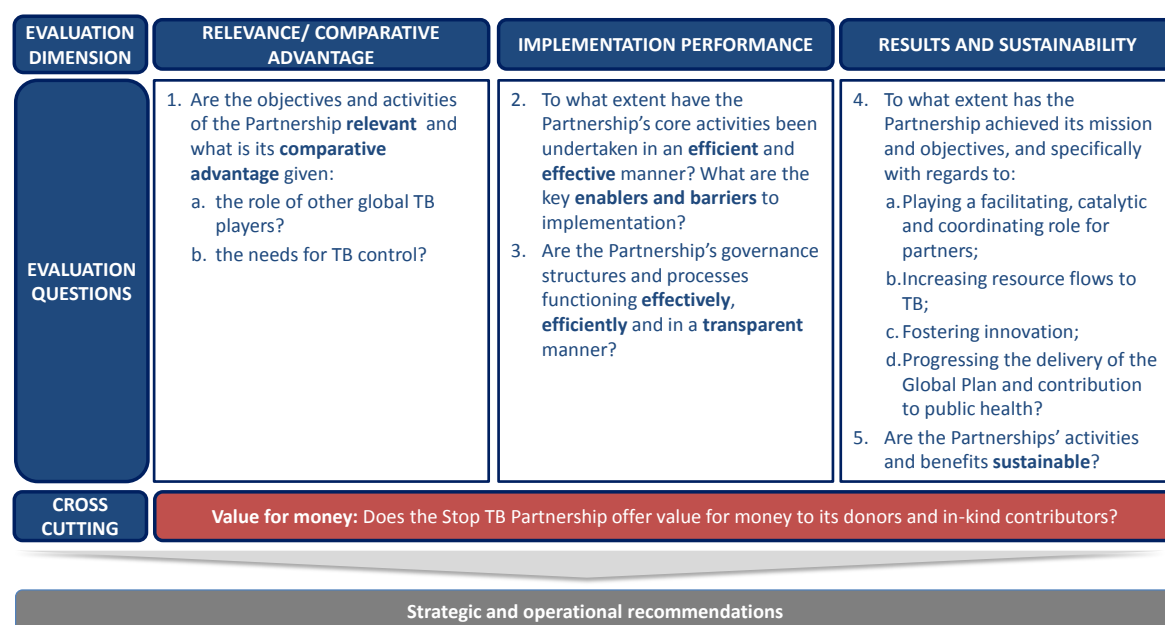
EXECUTIVE SUMMARY

This is the executive summary of Cambridge Economic Policy Associates’ evaluation of the Stop TB Partnership and comprises an overview of the evaluation objectives, methods, findings and recommendations.

The Stop TB Partnership was launched in 2001 with the aim to eliminate TB as a global public health problem by 2050 through partnership-building, advocacy and communication as well as the work of its three facilities – the Global Drugs Facility (GDF), TB REACH and the Challenge Facility for Civil Society (CFCS). The objective of the evaluation is to assess the Value for Money (VfM) of the Partnership over the period 2007-13, with a “light touch” review of the three facilities. Key to note is that the evaluation has been conducted in a “dynamic” environment wherein several reviews have recently been completed and reforms initiated, with it being too early to assess the full impact in this evaluation. Notably, the Partnership has changed its hosting arrangements from the World Health Organization (WHO) to the UN Office for Project Services (UNOPS) in January 2015 which is outside the scope of this review.

The evaluation framework has been structured across three dimensions of: (i) relevance/comparative advantage; (ii) implementation performance; and (iii) results and sustainability, to inform the assessment of VfM, which has been posited as a cross-cutting evaluation question (Figure 1). A mixed-methods approach has been employed focusing on document and data review as well as structured interviews.

Figure 1: Evaluation framework



We present an overview of our main findings across the three evaluation dimensions, followed by our conclusions on the VfM of the Partnership and proposed recommendations.

Evaluation dimension 1: Relevance and comparative advantage

The Stop TB Partnership is a highly relevant organisation, with a critical role to play in advocacy and partnership-building for TB. It has a very relevant role in fostering innovation in case detection through TB REACH and providing quality TB drugs and diagnostics and country supply systems support through GDF. Its relevance has improved following the development of a new Operational Strategy for 2013-15 as well as a new strategic framework for GDF in 2013, which have prioritised and streamlined the activities in relation to its comparative advantage and resource availability. However, the Partnership needs to continue to further clarify its objectives and certain activities (e.g. on partnership-building, evolving role of GDF in relation to the Global Fund) to further improve its relevance.

The Partnership is uniquely placed within the global TB architecture to galvanise the TB response by advocating, bringing together and coordinating the views and efforts of all relevant partners (both state and non-state) in a neutral and inclusive way. The Partnership is the only organisation serving as a convenor / coordinator of the range of different actors working on TB control and hence represents a relevant response to the current and future needs for TB control.

Evaluation dimension 2: Implementation performance

The Partnership has faced a number of key issues that have impacted implementation efficiency and effectiveness including: (i) the absence of a clearly defined strategy; (ii) declining financial resources (after 2011) and increasing specified funding; (iii) strategic, operational and financial limitations related to its hosting arrangements at WHO; and (iv) high staff turnover. A number of these issues have been/ are being addressed towards the end of our evaluation period – specifically the development of a new Operational Strategy from 2013 and new hosting arrangements at UNOPS from 2015 – with some early achievements and the potential for improved efficiency and effectiveness of performance.

We have examined the approach and delivery of the Partnership's four core areas of work and conclude the following:

- *Advocacy and communications* activities have historically lacked focus and been constrained under the WHO hosting arrangements. However this area of work has become more specific and streamlined following the development of the new strategy, with some high-profile early achievements (e.g. with the Global Fund, TB and mining in southern Africa) and greater potential for impact going forward.
- *Partnership-building* activities have worked well with regards to engagement with TB communities and advocates (e.g. through CFCS, working with the Global Fund to support community engagement). However the Working Groups, as a core partnership-building approach, have been fraught with a number of operational and management issues. More generally, this area of work of the Partnership needs more clarity and definition in terms of priority activities and approach.

- *TB REACH* has been an important success of the Partnership and has made several reforms following the recommendations of its mid-term review. Sustainability and scalability of successful projects is an area that requires continued efforts.
- *GDF* has faced a number of challenges over the evaluation period brought on by changes in the external TB environment. In 2013 it developed a new strategy to ensure its relevance in relation to evolving TB landscape and country needs; however, these need to be kept under review to ensure *GDF*'s ongoing relevance.

Governance and management arrangements have been subject to considerable recent reforms. Major Board reforms were introduced over 2011-12 which appear to have greatly improved effectiveness, through improved clarity of roles and procedures as well as improved constituency representation. Some efficiency improvements have been noted, although as these reforms were enacted late in the evaluation period, their full impact remains to be seen.

Another reform process has been underway alongside this evaluation is to address strategic and operational challenges facing the Working Groups (including unclear objectives, severe funding shortfalls and inadequate accountability mechanisms). It remains to be seen whether these reforms and the new proposed "Standard Operating Procedures" will have the necessary impact on the Working Groups' performance and value-add.

Finally, there has been unanimous feedback that the work of the Secretariat has been impressive, especially in the context of the challenges they have faced with regards to limited resources.

Evaluation dimension 3: Results and sustainability

The Partnership's monitoring and evaluation (M&E) arrangements are inadequate in that: (i) there is no unified and overarching logframe/ results framework that brings together the activities and funding of the Partnership as a whole; (ii) a number of its Key Performance Indicators (KPIs) are ambiguous and not detailed enough; and (iii) reporting has focused more on activities than on results. *TB REACH* and *GDF* M&E has been more effective, however not adequately integrated with other aspects of the Partnership's work.

Notwithstanding the challenge posed by ineffective M&E on our evaluation work, we conclude that the Partnership has made a number of important achievements including:

- *Playing a facilitating, catalytic and coordinating role for partners* – most notably through strengthened engagement with the Global Fund since 2011, which has contributed to increased allocation of resources for TB from 16% to 18% of the 2014-16 allocation; timely and higher TB grant disbursement to countries (US\$726m through 130 TB grants in 2013, which was noted as "*the highest-ever amount of funds disbursed for TB*") and greater engagement with communities.
- *Increasing resource flows to TB* – in addition to increased support for TB from the Global Fund as described above, the Partnership has contributed to potential

additional domestic and regional financing for TB through targeted advocacy initiatives:

- on TB and mining in southern Africa, contributing to the first ever Declaration by Heads of State on TB being signed in 2012, which led to the launch of a US\$102m regional initiative of the Global Fund to provide additional funding to Southern African Development Community (SADC) countries and a US\$100m allocation by the World Bank; and
- with BRICS Ministers of Health, contributing to the signing of two joint statements in 2013 on their commitment to cooperation for TB care and control and the formation of a BRICS Technical Task Force on TB and HIV.
- *Fostering innovation* – through the work of the TB REACH initiative, which has supported innovations including the first time introduction of a technology in a country (e.g. GeneXpert), approaches that have not been routinely practiced before (e.g. public-private models for TB diagnosis), and improving access of essential services to otherwise deprived or high-risk population groups (e.g. introduction of TB screening for border immigrants, prisoners and nomadic groups).
- *Contribution to the Global Plan* – through 38,413 additional Bac+ cases detected by projects in TB REACH Waves 1 and 2 (as well as additional patients reached through the grants provided by CFCS) and supply of 14,728,782 patient treatments worldwide at reduced prices by GDF, alongside other commodities such as diagnostics. For example, in 2013, GDF was able to reduce the price of several Second Line Drugs (SLDs) by up to 27% compared to 2011 prices. The various price reductions on SLD treatment regimens from 2011-14 have resulted in savings of US\$21.3m in the first half of 2014 alone.

Finally, we have also reviewed the sustainability of the Partnership and conclude that this is a major risk going forward unless the Partnership is able to increase and diversify its donor base in the near term.

Conclusions on Value for Money

The Partnership provides good “value” by virtue of being an extremely relevant organisation in the global response to TB and having made a number of important achievements including contributing to increased donor (Global Fund) and country efforts/ resources for TB; strengthened community engagement in various TB platforms; development of innovative approaches to case detection through TB REACH; and increased supply of TB commodities at reduced prices through GDF.

The Partnership’s administrative costs are broadly comparable to that of other similar organisations, and its Secretariat has been regarded as very efficient by a range of its stakeholders. However, the Partnership as a whole has incurred considerable inefficiencies, especially in the early years of the evaluation period, due to the lack of a comprehensive

strategy to guide its work; inadequate monitoring due to the absence of an M&E framework; a number of issues with its hosting arrangements; and high staff turnover.

Recent reforms have been or are being introduced to improve these issues – notably the development of the 2013-15 Operational Strategy, new hosting arrangements at UNOPS and several governance reforms for its Coordinating Board and Working Groups – with these exhibiting early results and having considerable potential for more effective working and results in the future.

Therefore, although in the early years of the evaluation period of 2007-13, the Partnership lacked focus and faced increasing costs, in more recent years it has taken substantial reform efforts to improve its efficiency and effectiveness – and thus represents positive and improving VfM to its donors. As some of the reform process is ongoing/ completed recently, the current period is critical for the Partnership to demonstrate improved VfM and should be reviewed closely.

Recommendations

As noted, major changes have been made at the Partnership, notably the change in hosting arrangements from WHO to UNOPS. As such, some issues/ weaknesses of the Partnership are being currently addressed and the Partnership has evolved beyond the description provided in this evaluation report. Therefore, we provide a few key recommendations as outstanding areas requiring further work.

Recommendation 1: Develop a detailed and comprehensive strategy for 2016 onwards with a clear delineation of the overall goals and objectives; linkages between the four areas of work and the achievement of these objectives; and approach and key principles for delivery.

Recommendation 2: Further define partnership-building and engagement activities including prioritisation of key activities in line with resource availability; a clear approach to how the Stop TB Partnership would engage with its partner base; and improved functioning of the Working Groups.

Recommendation 3: Develop a unified M&E framework and approach for progress monitoring, including relevant and measureable KPIs that relate to the work of the Partnership.

Recommendation 4: Focus efforts on resource mobilisation for the Partnership's activities through the development of a focused resource mobilisation strategy and allocation of adequate resources to ensure its effective delivery.

1. INTRODUCTION

Cambridge Economic Policy Associates (CEPA) has been appointed to conduct an evaluation of the Stop TB Partnership (hereinafter referred to as “the Partnership”), with a focus on an assessment of its Value for Money (VfM) over the period 2007-13.¹ This report presents our evaluation findings, conclusions and recommendations.

It is important to note that the Partnership has recently undergone substantial reform with a change in hosting arrangements from the World Health Organization (WHO) to the UN Office for Project Services (UNOPS) from 1 January 2015. However, our evaluation does not review this change (which has been subject to detailed review previously) or its outcomes (as these are being experienced at present given the recent move and are outside the period of review).

In the introduction section, we provide a brief description of the Stop TB Partnership (Section 1.1), the evaluation scope and objectives (Section 1.2), important context to the evaluation (Section 1.3) and the structure of the report (Section 1.4).

1.1. Overview of the Stop TB Partnership

Founded in 2001, the Stop TB Partnership is a global movement of almost 1,300 partners, aimed at eliminating Tuberculosis (TB) as a global public health problem by 2050. Its focus is on partnership-building and advocacy and communication for TB, and it also includes three facilities/ initiatives, namely: (i) Global Drug Facility (GDF) – which is a procurement mechanism for TB commodities; (ii) TB REACH initiative – which aims to fund innovative approaches to TB case detection; and (iii) Challenge Facility for Civil Society (CFCS) – which provides small grants to promote the role of communities in National Tuberculosis Programmes (NTP) and other platforms.

The Partnership is funded by a range of donors including bilateral donors and government agencies (UK Department for International Development (DFID), United States Agency for International Development (USAID), Canadian International Development Agency (CIDA), Government of the Netherlands, United States Centre for Disease Control (CDC)), multilateral organisations (World Bank, UNITAID, Global Fund), foundations (Bill and Melinda Gates Foundation (BMGF), Kochon Foundation, Eli Lilly Foundation), and some in-kind contributions. Over the period 2007-13, the Partnership experienced an increase in funding until a peak of US\$110m in 2010, followed by a decline to US\$78m in 2013. Both historically and at present, GDF represents the largest share of Partnership funding, at approximately two-thirds of total Partnership expenditure in most years.

As noted, the Partnership was hosted by WHO from inception to end-2014 and is now hosted by UNOPS. It comprises a Coordinating Board responsible for overall governance, Working

¹ www.cepa.co.uk

Groups structured around key TB research and operational issues and a Secretariat for day-to-day management of the Partnership's work.

1.2. Evaluation scope and objectives

The objective of the assignment is to conduct a VfM assessment of the Partnership, covering the period 2007 to 2013. The specific objectives outlined in the Terms of Reference (ToR) are to assess whether the Partnership:²

- offers VfM to its donors, delivering maximum benefit to its stakeholders within the available resources in an effective, efficient and sustainable manner;
- offers additionality through its work, in terms of providing value-add to the individual efforts of its partners for controlling TB; and
- has appropriate arrangements for effective management and efficient operational processes to enable it to function in an optimal manner.

The ToR also provide additional detailed evaluation questions and issues for assessment. However, following discussions with the Partnership Secretariat at the start of the assignment, we have agreed to review the above-noted aspects in a relatively *“light touch”* manner, due to the reduced overall budget available for the evaluation from that envisaged during the development of the ToR.

The evaluation focuses on a review of the Stop TB Partnership as an advocacy and partnership-building organisation and does not entail a *“deep dive”* into the functioning and performance of GDF, TB REACH and CFCS. GDF in particular, being a wide-ranging and evolving facility, has not been subject to detailed review in this evaluation. In addition, the evaluation draws on the recent strategy, governance and hosting reviews conducted for the Partnership and does not aim to *“reinvent the wheel”* in terms of the issues examined under these reviews.

1.3. Key context for the evaluation

It is important to note the *“dynamic”* environment within which the evaluation has been conducted to appreciate its scope as well as recognise its limitations. The following are key changes that have taken place recently or are currently in motion, and while not the focus, have important implications for this evaluation and ensuing recommendations:

² Request for Proposals No. 2014/HTM/TBP/001, Annex 1 – ToR – *“Value for Money”* Independent External Evaluation of the Stop TB Partnership.

Development of a new Partnership strategy for 2013-15 has implied limited utility and information on areas of work prior to 2013 that have not been included in this strategy.

In 2012, the Board requested the development of a three-year Operational Strategy that prioritised and streamlined the work of the Secretariat based on its comparative advantage and financial resources. The new Strategy has been implemented since January 2013, and while the overall thrust of the Partnership's work has not changed, there have been a number of changes in the activity focus and approach to delivery. As such, while we highlight key issues faced by the Partnership over the evaluation period, we concentrate on relevant areas going forward.

In addition, there has also been high turnover within the Secretariat, and coupled with the new ways of thinking under the new strategy, there has been considerable paucity of information on the earlier years of our review period.

Change in hosting arrangements is expected to "remedy" key issues faced by the Partnership in its earlier years, however does not fall within the scope of this evaluation.

An in-depth hosting review study was conducted in 2013 and the Partnership's hosting arrangements have been shifted from WHO to UNOPS in January 2015.³ This change in hosting arrangements has not been in scope for this evaluation, and as such, we have not reviewed the context, the benefits and costs of alternate hosting arrangements and the outcomes of the recent change. Some of the issues discussed in our evaluation will be impacted by the change in hosting arrangements, which was completed during the course of this evaluation.

The change in hosting arrangements has also resulted in a delayed timeframe for this evaluation.

Several recent reviews have identified key issues and reforms are in progress, with it being too early to assess improvements.

There have been a number of reviews of the Partnership in recent years. In addition to the Operational Strategy mentioned above, the Partnership has undergone a full governance reform, and since July 2013, has a new Board structure and related processes. The Partnership is also reviewing its Working Groups and has developed Standard Operating Procedures (SOPs) for these groups. Further, a critical review of GDF's comparative advantage was conducted in 2010, following which GDF has developed a renewed focus and strategy in October 2012 (implemented from 2013). A mid-term evaluation of TB REACH was also conducted in 2012-13 and a number of the recommendations are presently being implemented.

As such, our evaluation is being conducted at a time when there are recent/ ongoing changes within key components of the Partnership. Key issues faced during the initial years of its

³ Boutel T., Vijay A., and Szabo' R. (2013) Independent review of Hosting Arrangements, Stop TB Partnership. Also referred as "Hosting Review" in this evaluation.

operations have already been identified and a revised approach proposed in these reviews. The efficacy of these reforms remains to be seen and is too soon to assess under this evaluation.

1.4. Structure of the report

The report is structured as follows:

- Section 2 sets out our evaluation framework, methods and limitations;
- Section 3-5 present our evaluation findings across the review dimensions;
- Section 6 brings together our key evaluation findings to analyse and conclude on the VfM of the Partnership; and
- Section 7 presents our recommendations for the Partnership.

The report is supported by the following annexes (included as a separate document):

- Annex 1 provides a bibliography;
- Annex 2 presents the list of stakeholders consulted;
- Annex 3 presents the interview guide;
- Annex 4 presents a mapping of the global TB control architecture;
- Annex 5 reviews the Partnership's activities and results as reported in its Annual Reports between 2007-13;
- Annex 6 examines the Partnership's partner base;
- Annex 7 reviews the CFCS;
- Annex 8 summarises the progress made by TB REACH on the recommendations of its mid-term review;
- Annex 9 presents some measures of TB REACH and GDF Secretariat efficiency;
- Annex 10 provides additional information on the TB funding landscape;
- Annex 11 analyses the portfolios of GDF, TB REACH and CFCS, primarily in terms of their country focus; and
- Annex 12 provides a high-level benchmarking analysis of the Partnership with the Partnership for Maternal, Newborn and Child Health (PMNCH) and Roll Back Malaria (RBM).

2. EVALUATION FRAMEWORK AND METHODS

This section presents our evaluation framework (Section 2.1) as well as key evaluation methods and their limitations (Section 2.2).

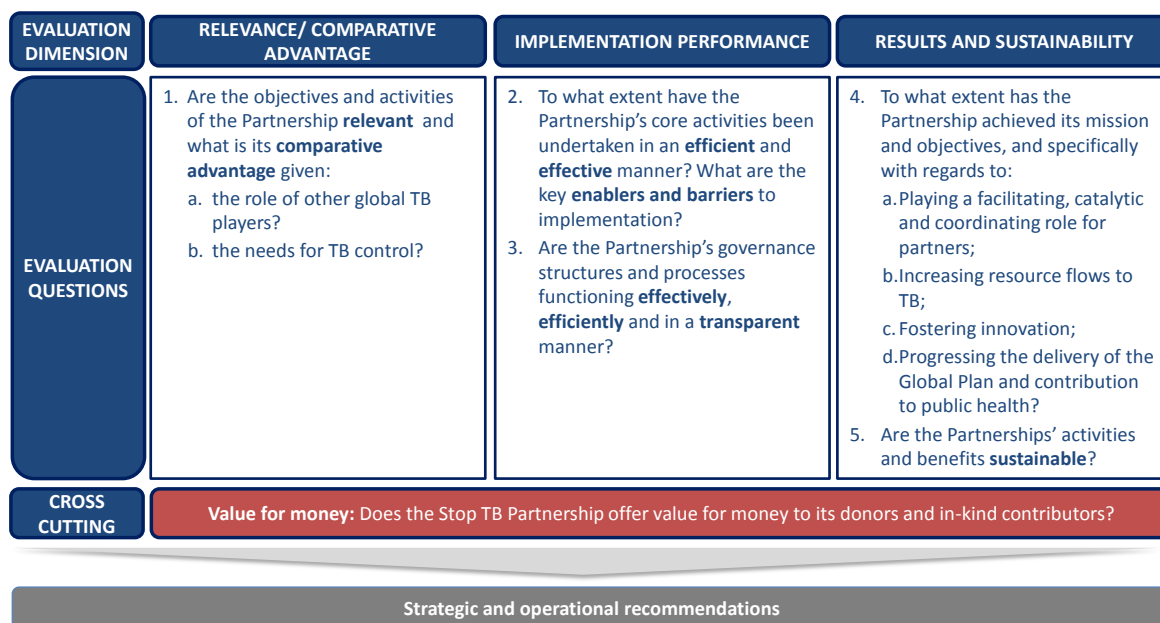
2.1. Evaluation framework

Figure 2.1 presents our evaluation framework which comprises three inter-related evaluation dimensions of:

- **Relevance/ comparative advantage:** encompassing an assessment of the relevance of the Partnership’s objectives and activities as well as its comparative advantage given the role of other global TB players and the needs for TB control.
- **Implementation performance:** examining the efficiency and efficacy of the implementation of the Partnership’s areas of work as well as its governance and management arrangements.
- **Results and sustainability:** focusing on the results of the Partnership’s activities with regards to playing a facilitating, catalytic and coordinating role, increasing resource flows to TB, fostering innovation and progressing the Global Plan and contribution to public health; as well as performance with regards to sustainability.

Within each dimension, we have structured specific evaluation questions that capture key issues relevant for this evaluation and inform our analysis on the overarching evaluation objective of VfM, which we have captured as a cross-cutting question. Our findings across the evaluation have contributed to the development of recommendations to improve the effectiveness of the Partnership going forward.

Figure 2.1: Evaluation framework



2.2. Evaluation methods and limitations

Key evaluation methods employed for this work include:⁴

- **Desk-based review of documents:** Our desk-based review has encompassed key Partnership documents such as the strategy documents, recent evaluations, annual reports, internal management and monitoring and evaluation (M&E) documents, organograms, news bulletins, the 2006-15 and 2011-15 Global Plans to Stop TB, amongst others. We have also reviewed the broader TB literature including WHO Global Tuberculosis Reports and The Lancet's Tuberculosis 2014 Series. Annex 1 provides a bibliography.
- **Consultations:** In-depth interviews were conducted with members of the Partnership Board, Secretariat, GDF, CFCS, TB REACH and Working Groups, as well as a number of external stakeholders, including donors and partner organisations. Interviews were conducted during face-to-face meetings in Geneva and by telephone. Annex 2 provides the list of consultees and Annex 3 presents the interview guide.
- **Quantitative analysis:** Key pieces of quantitative analysis conducted for the evaluation include: income and expenditure trends using Partnership financial reports (2007-13); trends in Partnership Full-time Equivalent (FTE) staff and staff costs (2008-13); and grant portfolio and results data for GDF, TB REACH, and CFCS (detailed in Annex 11). Analysis of the wider trends in TB financing and results have been based on publicly-available data from the Institute for Health Metrics and Evaluation, the Global Fund and the academic literature on TB (Annex 10).
- **Comparator analysis:** We have conducted a comparator analysis of two similar partnerships, namely: (i) PMNCH and (ii) RBM Partnership to draw lessons for the Stop TB Partnership (detailed in Annex 12). While recognising that no two organisations are alike, these comparators offer similarities with the Partnership in the sense of being partner-based organisations with an advocacy/ communications mandate in their respective health sectors of focus.

Our evaluation conclusions are based on a collation of the available evidence (drawing on the evaluation methods described above), also assessing the quality (i.e. data quality, type of stakeholder group consulted for a particular evaluation question) and uniformity (i.e. triangulation) of the evidence. This has been supplemented by our informed judgment on the interpretation of the evidence, drawing on our knowledge and experience with evaluations.

The main limitations of the evaluation methods are as follows:

⁴ We had originally proposed to conduct an e-survey given the qualitative nature of the evaluation. However the Secretariat has advised against the use of this evaluation method due to a degree of fatigue amongst its stakeholders given several recent strategy reviews and evaluations as well as the limited budget available for the evaluation.

- *Review of a limited number of activities:* Given the range of Partnership activities, we have not been able to review all activities over the evaluation period – not only on account of the budget and time available for the evaluation but also because there is limited information on a number of Partnership activities especially before 2011 (see next point).
- *Limited information on Partnership activities and approaches before 2011:* There has been limited documentation of the rationale and scope/ focus of key Partnership activities before 2011. Where these are available, it has been challenging to understand their full context/ intention given high staff turnover and limited institutional memory within the Partnership.⁵ This has resulted in more of an emphasis on the second half of our review period of 2007-13.
- *Lack of availability of full data:* Although access was provided to Partnership data, some data was not available for all years. For example, staff numbers and salaries were not available for 2007; financial data was also not available with the same level of detail for all years; amongst others.
- *Few stakeholder groups not consulted and some degree of consultation bias:* Although we have tried to interview a wide range of Partnership stakeholders, due to budget constraints we have not been able to adequately cover all stakeholder groups (e.g. in-country partners and beneficiaries of the Partnership’s grant-facilities are under-represented in our consultee list). As is the case with most evaluations, our interviews are impacted by consultee bias, especially given the large number of Secretariat staff interviewed. That said, we have attempted to triangulate findings across stakeholder groups to minimise consultee bias.
- *Difficulty in drawing meaningful conclusions from the comparator analysis due to lack of complete information:* There has been limited publically available information on the two comparator partnerships (mainly RBM), especially in terms of their costs, and we have been unable to gather additional information from consultations. As such, the comparator analysis has been limited to the information that is available.

⁵ For example, pre-2011 there were annual Advocacy Frameworks which summarised advocacy objectives and activities, but current staff were not aware of them.

3. RELEVANCE AND COMPARATIVE ADVANTAGE

This section presents our analysis and findings on the relevance and comparative advantage of the Stop TB Partnership. Our evaluation question is as follows:

Qs 1: Are the objectives and activities of the Partnership relevant and what is its comparative advantage given: (i) the role of other global TB players; and (ii) the needs for TB control?

As part of our review, we consider the objectives of the Partnership (as represented by its mission and strategic goals) as well as its main areas of work (which have remained broadly consistent since its establishment, albeit with some changes to activities). We review the “fit” of the Partnership with other global players in the TB landscape, in terms of the extent to which it plays a unique role and complements rather than duplicates their work. We also review the role of the Partnership given current and future needs for TB control.

The section is organised as follows: Section 3.1 discusses the relevance of the Partnership’s mission, objectives and areas of work, Section 3.2 reviews the comparative advantage of the Partnership vis-à-vis other global players and Section 3.3 discusses its relevance given needs for TB control. A summary assessment is provided at the end of the section.

3.1. Relevance of Partnership mission, objectives and areas of work

The Stop TB Partnership is a network of TB partners across the world that aims to act as a “collective force” to “reduce the toll of TB worldwide and ultimately achieve a world free of TB”.⁶ The Partnership’s mission has remained constant over the years and seeks to “*ensure that every TB patient has access to effective diagnosis, treatment and cure; stop transmission of TB; reduce the inequitable social and economic toll of TB; and develop and implement new preventive, diagnostic and therapeutic tools and strategies to stop TB*”.⁷

While an extremely relevant and important mission, in our assessment, it is fairly high level in relation to the “upstream” nature of activities of the Partnership such as advocacy and communications for TB. This may have also contributed to the somewhat lack of clarity of the role of the Partnership (e.g. in terms of its focus at the global rather than country level) and its intended achievements amongst a few stakeholders. We note that other partnerships with a broadly similar mandate (albeit in different health sectors) have developed more focused missions that are more closely aligned with their activities. For example, PMNCH’s mission is reflective of the “level” of its work and is “Supporting partners to align their strategic directions and catalyse collective action to achieve universal access to comprehensive, high-quality reproductive, maternal, newborn and child health care”.

⁶ Stop TB Partnership (2012) 2013-2015 Operational Strategy, Stop TB Partnership Secretariat, World Health Organization.

⁷ Stop TB Partnership (2001) Basic Framework for the Global Partnership to Stop TB, Stop TB Partnership Secretariat, World Health Organization.

The Partnership has recently developed an Operational Strategy for 2013-15, which sets out its four Strategic Goals and related objectives. The Strategic Goals are as follows:

- *Strategic Goal 1:* Facilitate meaningful and sustained collaboration among partners.
- *Strategic Goal 2:* Increase political engagement by world leaders and key influencers to double external financing for TB from 2011 to 2015.
- *Strategic Goal 3:* Promote innovation in TB diagnosis and care through TB REACH and other innovative mechanisms and platforms
- *Strategic Goal 4:* Ensure universal access to quality assured TB medicines and diagnostics in countries served by the GDF.

Documentary evidence (primarily the analysis conducted for the development of the new strategy) and stakeholder feedback on the relevance of the Partnership's objectives and areas of work are as follows:

- **Increasing relevance of the Partnership under the new streamlined strategy:** While the Partnership's broad areas of work have not changed, the new strategy has aimed to streamline the work of the Partnership and focus its activities on specific areas where it has a comparative advantage, given limited resources. This streamlining effort has improved the relevance of the Partnership, with stakeholders noting that a more focused approach and de-prioritisation of "limited impact" activities provides greater potential for results. However, there is a need to further develop and describe the strategy, including in terms of the approach to certain objectives and developing a consolidated M&E framework for the Partnership as a whole (discussed further in the sections below).
- **Critical importance of its role in advocacy and partnership-building:** A recent partner's survey was conducted in support of the development of the new strategy wherein both partnership-building and advocacy were seen as key roles of the Partnership. Related to advocacy, resource mobilisation efforts for TB were viewed as very important – including engaging with the Global Fund and G8 countries. All of our consultations also emphasised these as key roles of the Partnership.
- **Relevant role in fostering innovation in case detection through TB REACH:** On TB REACH, the 2013 mid-term evaluation concluded the following with regards to its relevance: *"TB REACH is a highly relevant funding mechanism in the context of the need for innovative approaches to improve TB case detection and limited funding by other donors for such interventions. There has generally been a good degree of coordination of TB REACH projects with NTPs and country health systems, although not uniformly across countries"*.⁸ Some consultees noted that the Partnership as a

⁸ CEPA (2013) Mid-term Review of the TB REACH Initiative.

whole has an important role to play with regards to innovation in the TB sector and this could be emphasised more strongly in the future.

- **Evolving key role of the GDF.** GDF has aimed to improve its relevance over the years with a number of reviews of its strategic direction over the 2010-13 period. Today, along with its key role in the procurement of first line drugs (FLDs) and paediatric TB drugs, it is the sole procurement mechanism for second-line TB drugs (SLDs) for the Global Fund, making it a highly relevant initiative. However some stakeholders have commented on the relatively long “transition period” for defining its comparative advantage and the need to continue to monitor its role given the changing TB landscape, and especially the approach and activities of the Global Fund.

Thus, the Stop TB Partnership focuses on a range of relevant objectives and activities, and the recent streamlining of its work has helped improve its relevance further. However more could be done to specify/ clarify certain objectives and areas of work (discussed further in Section 4).

3.2. Comparative advantage vis-à-vis other global players

We have undertaken a mapping of the key players in the global TB landscape to assess the comparative advantage of the Partnership – focusing on its overall role rather than specific activities of TB REACH and GDF (see Annex 4). The mapping encompasses bilateral donors, multilateral organisations, foundations, international Non-Governmental Organisations (INGOs) and technical organisations, categorised into four broad groups based on their main role: (i) funders; (ii) technical assistance providers; (iii) research and development (R&D); and (vi) advocacy (recognising that some organisations play more than one of these roles). We have examined the overall mandate, main activities, areas of focus within TB, level of funding and geographic focus for each organisation.

Our mapping exercise highlights the comparative advantage of the Partnership as:

- **The only organisation serving as a convenor/ coordinator of the range of different actors working on TB control,** including both state and non-state actors. This role was also strongly highlighted during *all* of our consultations, with consultees noting that the Partnership is the only organisation that brings together the different players in the TB landscape. It was noted that the WHO Global TB Programme plays an important coordinating role with country governments, however due to the mandate of WHO, it does not extend this role to other key TB players. The Partnership serves to represent all TB stakeholders in an un-biased/ non-partisan way, lending it the necessary legitimacy to represent its partners. The Partnership therefore has a unique role in the global TB landscape, making it a highly relevant organisation.
- **A wide-ranging platform for TB advocacy globally:** Through its convening/ coordinating role, the Partnership is able to advocate for TB control to a range of stakeholders. Consultees noted that the Partnership plays a unique advocacy role

through its engagement with both high-level ministers and decision-makers (both with donor and recipient country governments) and with smaller Civil Society Organisations (CSOs) and TB-affected communities. Partners working on TB advocacy noted that the Partnership has served as an important platform for public awareness-raising through the development of generic messages and tools which are broad enough for its partners to adapt in varying country contexts.

The mapping exercise also highlights that the Partnership works closely with the key donors and other partners to complement their work on TB and avoid duplication of efforts. For example, the Partnership sits on the Board of the Global Fund and UNITAID and conducts a number of joint activities with the WHO, the Union, UNAIDS and the Global Coalition of TB Advocates (GCTA).

Thus, the Partnership is uniquely placed within the global TB architecture to galvanise the TB response by advocating, bringing together and coordinating the views and efforts of all relevant partners in a neutral and inclusive manner.

3.3. Relevance given current and future needs for TB control

Despite positive progress over the past few years, in 2013, it was estimated that 9m people developed TB and 1.1m died from the disease (including 360,000 HIV-positive individuals).⁹ Of the 9m incident cases, 5.7m were detected and notified to the NTP or national surveillance systems, resulting in a Case Detection Rate (CDR) of 64% or approximately 3.3m “missed” cases. Globally, the 22 High Burden Countries (HBCs) accounted for 82% of the estimated cases, with India and China alone accounting for 24% and 11% of the global cases respectively. As such, there is a substantial need to support improved TB case detection and treatment in countries and the Stop TB Partnership presents a relevant and important response through the range of its functions and activities.

In particular, the Partnership is actively working on the key gaps and challenges highlighted in the 2014 Global TB Report, including supporting the needs for TB treatment through GDF procurement of drugs and commodities, with an increasing focus on procuring SLDs; improved TB case detection, through TB REACH funding of innovative approaches to increase the number of TB cases identified; R&D and the development of new tools (including global laboratory strengthening), through the work of the research Working Groups on new TB vaccines, diagnostics and drugs and the Global Laboratory Initiative (GLI); raising of finance, through its renewed focus on global level advocacy, including working closely with the Global Fund and BRICS countries (Brazil, Russia, India, China and South Africa); the co-epidemic of TB/ HIV, through coordinating the TB response with UNAIDS and the Global Fund; amongst others.

⁹ WHO (2014) 2014 Global TB Report, World Health Organization, Geneva, p.xi.

Further, while TB is a poverty-related disease, the TB epidemic has historically been “medicalised” initially resulting in hospital-based diagnosis and treatment by doctors/clinicians. With the introduction of a more “public health approach” in the last few decades, TB control has mainly been the domain of public national health systems; however, in recent years there has been a repositioning of the approach to TB aimed at engaging all stakeholders, from communities to the private sector. In the context of this paradigm shift, the Partnership is well-placed to bring together partners across all constituencies to ensure a holistic response to TB control. In particular, the Partnership has a strong role to play in supporting the engagement of non-state actors and communities in their response to the epidemic, as it has been doing through initiatives such as the CFCS and recent efforts with supporting community representation in country concept notes for Global Fund support. Going forward and through the change in hosting arrangement the Partnership will have the potential to engage with an even wider range of partners, especially in relation to the private and for-profit sectors.

Summary assessment:

- The Stop TB Partnership objectives and areas of work are highly relevant, with its relevance having improved following the more strategic and streamlined approach under the new Operational Strategy for 2013-15. However, the Partnership needs to further specify certain objectives and activities (e.g. on partnership-building, evolving role of GDF in relation to the Global Fund).
- The Partnership’s comparative advantage in the global TB architecture is in terms of its role in bringing together both state and non-state actors working on TB control – a unique role that is not played by any other organisation and is critical to meet the current and future needs for TB control.

4. IMPLEMENTATION PERFORMANCE

This section presents our analysis and findings on the implementation performance of the Stop TB Partnership over the period 2007-13. Our review focuses on the efficiency and efficacy of the Partnership's activities as well as its governance and management arrangements. Our evaluation questions are as follows:

Q2: To what extent have the Partnership's core activities been undertaken in an efficient and effective manner? What are the key enablers and barriers to implementation?

We examine the Partnership's four areas of work (i.e. advocacy and communications, partnership-building, TB REACH and GDF) in terms of their approach and delivery, considering any issues that may have impacted efficient and effective performance. As noted in Section 1, our assessment of TB REACH and GDF is at a high-level.

Q3: Are the Partnership's governance structures and processes functioning effectively, efficiently and in a transparent manner?

We assess the appropriateness and performance of the Partnership's governance structures, including the Coordinating Board, the Secretariat and the Working Groups.

The section is organised as follows: Section 4.1 provides a brief description of the Partnership's core areas of work, followed by Section 4.2 on overarching issues impacting implementation efficiency and efficacy and Section 4.3 on approach and delivery by area of work. Thereafter, Section 4.4 reviews governance and management arrangements. A summary assessment is provided at the end of the section.

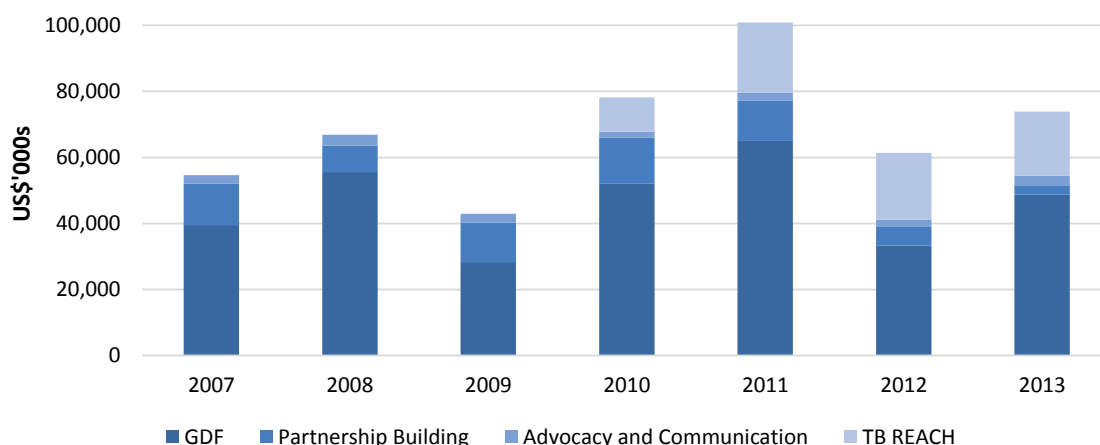
4.1. Partnership core areas of work

The Partnership has four core areas of work:

- advocacy and communications;
- partnership-building;
- TB REACH; and
- GDF.

As shown in Figure 4.1 over page, over the period 2007-13, GDF has been the largest area of funding, accounting for more than 65% of total expenditures in most years. Since its launch in 2010, TB REACH has also become a major area of work and increasingly so over the years, whilst advocacy and communications as well as partnership-building activities have accounted for a much lower and declining share over time.

Figure 4.1: Partnership expenditure across areas of work, US\$'000s (2007-13)¹⁰



Source: CEPA analysis from Stop TB Partnership Annual Financial Reports

4.2. Overarching issues in implementation

Over the evaluation period, there have been a number of issues that have affected the Partnership's work, as discussed below.

Lack of a clearly defined strategy

Historically, the Partnership has lacked a clearly defined strategy, setting out its activity focus and approach to achievement of its objectives, both for individual areas of work and comprehensively for the Partnership as a whole. Although initially guided by the objectives in the Stop TB Basic Framework (developed in 2001) and later by the goals of the Global Plan (starting in 2001 and updated in 2006 and 2010), its overall approach has lacked focus, been fragmented and undertaken in an opportunistic way based on resource availability (financial and staff).

Indeed, the development of the 2013-15 Operational Strategy in 2012 was borne out of a recognition of this situation. As noted in one of the strategy development documents, the Partnership recognised it "*[doesn't] have a clear strategy to achieve the Global Plan goals and [has] a lack of focus in [its] activities*".¹¹ The strategic exercise that was undertaken sought to provide a strategy that "*represents significant prioritisation and streamlining of the current activities and initiatives being undertaken today*".

Although the Operational Strategy is a first coordinated step towards structuring the activities of the Partnership across its four areas of work, our assessment as well as that suggested during stakeholder consultations, is that it is not comprehensive in that it does not describe

¹⁰ We have excluded "governance costs" from the total for partnership-building provided in the Annual Financial Reports as we view these costs as relating to the Partnership's activities as a whole (and not only partnership-building).

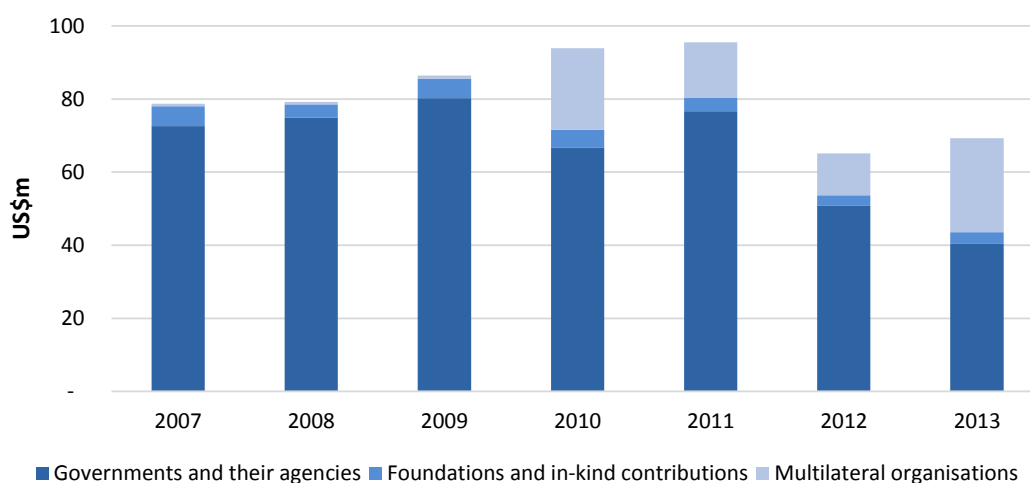
¹¹ Stop TB Partnership (2012) Operational Strategy: June Consultation Workshop, Pre-read, p.11.

the approach to implementation or set out a results framework. Our discussions with the Partnership indicate that it recognises this challenge and the need to further refine and strengthen its strategy.

Declining financial resources, including unspecified funds

Over the past few years, the Partnership has been operating in a resource constrained environment, which has impacted on its ability to deliver. Until 2011, the Partnership had enjoyed a period of strong funding growth; however from 2012, a combination of the global recession and the expiration of a number of multi-year donor agreements, coupled with the lack of a resource mobilisation strategy at the Partnership, has resulted in a period of declining revenues, as shown in Figure 4.2.

Figure 4.2: Funding to the Stop TB Partnership, US\$m (2007-13)¹²



Source: CEPA analysis from Stop TB Partnership Annual Financial Reports

Further, as noted in the 2013-15 Operational Strategy, “*Stop TB has been experiencing a steady decline in unspecified funds for some years, which was one of [the] considerations taken into account in the development of the Operational Strategy and was identified as a risk to Stop TB’s funding model in the Operational Strategy*”.¹³ In fact, with the expiration of multi-year donor funding agreements, donors have been channelling their specified funding to support GDF and TB REACH, leaving other activities such as advocacy and communications with severe funding shortfalls. Table 4.1 illustrates that in the 2012-13 biennium, Secretariat activities (which include funding for advocacy and communications, partnership-building as well as other areas of work) were underfunded compared to TB REACH and GDF.

¹² This excludes “prior year adjustments to income” included in the financial statements, as this is an accounting adjustment and not a source of revenue.

¹³ Hosting Review Report, Annex D, p.2

Table 4.1: Funding shortfall across areas of work (2012-13 biennium)

Item	Secretariat activities ¹⁴	TB REACH	Global Drug Facility
Planned budget	\$22.3m	\$46.9m	\$122m
Funding available	\$17m	\$46.9m	\$113.7m
Funding gap	\$5.3m	\$0	\$8.3m
% funding gap	24%	0%	7%

Source: Stop TB Partnership, Workplan and budget 2012/13, PPT presented at CB21 (30 Jan-1 Feb 2012)

Although the overall fundraising environment has become more challenging in recent years, we understand that the ability of the Partnership to raise funds has also been constrained by the hosting arrangement with WHO. For example, the Partnership has been restricted in raising funds from the private sector due to WHO’s policy for engagement with the private sector.¹⁵

Issues with hosting arrangements

The Partnership has been hosted by WHO since its inception until the end of 2014, which has had benefits as well as challenges – for example:

- As an entity hosted by WHO, the Partnership has had “*automatic credibility and respect*”,¹⁶ which was key during the earlier years of its establishment, especially in terms of connecting with Ministries of Health. Further, the shared mandate to eliminate TB facilitated information and expertise sharing and WHO’s robust internal management systems and networks helped establish greater accountability.
- But over the years, as described in the Hosting Review report, the hosting arrangement has prevented the Partnership from developing its own identity, resulting in low visibility of the Partnership’s work and considerable confusion with the work of WHO. The shared mandate has resulted in a competitive environment for fund raising and the governance arrangements have led to potential “organisation capture” by WHO.¹⁷ There have also been efficiency constraints with WHO’s Human Resources (HR) procedures.¹⁸

¹⁴ Funding gaps by Secretariat activity are as follows: special projects were the most underfunded (73% funding gap) followed by CFCS (63%), Working Groups (60%), National, Regional and Global Partnership activities (48%), Executive Secretary Office (46%), Communications (45%), Advocacy (34%) and Management and donor relations (19%).

¹⁵ Hosting Review Report, p.21.

¹⁶ Hosting Review Report, p.13.

¹⁷ A Partnership survey conducted in 2012 highlighted that although 75% of respondents understand the difference between the Partnership and the Stop TB Department at WHO, the majority of ‘partner’ respondents (i.e. excluding the Secretariat) were either neutral or disagreed with this statement, suggesting the need for greater clarity on the relationship between the Partnership and WHO. Ref: McKinsey Survey, p. 5.

¹⁸ As noted in the Hosting Review (2013) “Decisions relating to confirmation of probation, termination for poor performance and redundancy are particularly difficult for the Secretariat operating within WHO because of WHO’s aversion to the risk of litigation”, p. 19.

Consultations with the Secretariat as well as other stakeholders have indicated that the Partnership has been increasingly constrained to efficiently and effectively deliver on its mandate with the WHO hosting arrangements. This has especially been the case in recent years, where the relationship between the Partnership and WHO has been fairly strained. New leadership at the Partnership from 2010 has encouraged a discussion on the key issues and a move towards resolving through a change in hosting arrangements from WHO to UNOPS from January 2015.

The review of the hosting arrangements is outside the scope of this evaluation and the move has taken place only recently. However, we understand that some of the key challenges experienced are expected to improve.

Staffing and organisational issues

A number of staffing and organisational issues have also constrained the Partnership's performance including:

- *High staff turnover:* The number of FTEs has increased from 36 in 2008 to 58 in 2011, and then decreased to 49 in 2012 and 42 in 2013. Furthermore, the Partnership's organograms between 2008 and 2013 illustrate that there have been a number of changes in the team structure.¹⁹ These changes have contributed to a degree of discontinuity in the Partnership's work (although some of the recent changes/attrition also represents the need for fewer staff with the "sun-setting" of certain activities under the new strategy). There have also been frequent leadership changes at GDF, which we understand have hampered its effectiveness.
- *Limited collaboration and weak operational processes:* The development of the Operational Strategy in 2012 identified an ineffective operational structure, including lack of collaborative working (with some teams working in silos) and poor communication across teams. This was heightened by the lack of a systematic approach to the Secretariat's work processes and the need to "*develop (where absent) and to codify (where implicit) clear processes*"²⁰ that would ensure the Secretariat, and Partnership more broadly, could deliver on its activities.

There have therefore been a number of key issues that have impacted on the work of the Partnership over the period 2007-13. However, more recently with the development of the

¹⁹ For example, the 2008 organogram shows the Partnership has having four teams: (i) Executive Secretary Office; (ii) Admin; (iii) GDF and (iv) Advocacy, Strategy, Ambassadors and Partnerships. In 2009 and 2010, there was a separation across teams as follows: (i) Executive Secretary Office; (ii) Social mobilisation and partnering; (iii) Advocacy and Strategic Planning; (iv) Branding, Marketing and Communications; (v) GDF; (vi) TB REACH; and (vii) Admin and Finance. The 2010 organogram is similar to 2009 but for the Advocacy and Communications teams, which are merged into one. From 2011-13 the organograms are consistent and the Partnership is structured as follows: (i) Executive Secretary Office; (ii) Strategic Planning and advocacy; (iii) Communications; (iv) National and Global Partnerships; (v) GDF; (vi) TB REACH; and (vii) Admin and Finance.

²⁰ Stop TB Partnership (2012) Stop TB Operational Strategy, Summary of July 18-19 Steering Committee Workshop, p.5

new 2013-15 Operational Strategy as well as a change in the hosting arrangements from WHO to UNOPS, it is expected that some of these challenges will improve.

4.3. Key issues and performance by area of work

The above-noted issues have impacted on implementation performance across the four areas of work of the Partnership. We discuss each of the areas in turn below, also reviewing the Partnership's approach to delivery and any specific issues thereof.

4.3.1. Advocacy and communications

Since its establishment, advocacy and communications activities have been central to the work of the Partnership. Both our consultations and previous reviews have highlighted the key role of the Partnership in this area.

However, its delivery has been particularly affected by the issues discussed in the previous section – especially the lack of a clear strategy, which has resulted in wide-ranging and fragmented activities over the years. Our review of the Partnership's Annual Reports over the period 2007-13 (see Annex 5) illustrates that, while a number of important activities have been undertaken, there is: (i) no overall strategy and coordinating purpose for the various activities; and (ii) limited follow through of activities in successive years.²¹

From 2012 onwards, with the development of the Operational Strategy and a broader recognition that the Partnership needed to raise its advocacy profile, there has been greater streamlining of activities, with a renewed focus on high-level policy outreach and engagement with the Global Fund aimed at resource mobilisation for TB.²² Consultees have noted that while resource mobilisation has always been an area of focus for the Partnership, its work in this area has been somewhat diluted over the years, with a significant re-emphasis recently. In particular, the Partnership has been focusing its limited resources on select priority activities which have been deemed critical by stakeholders, including:

- *Enhanced and strategic engagement with the Global Fund* – for example, through proactive utilisation of the rotating seat for partners on the Global Fund Board; participation in Board Committees such as the Strategic Investment and Impact

²¹ We understand that there have been attempts to strategically position advocacy activities during the 2007-11 period – for example, there were annual Advocacy Frameworks up to 2011 (ref: McKinsey and Co. (2009) "Keeping the Advocacy Framework document relevant through just-in-time intelligence", PPT Discussion Document, 21 October 2009) and an Advocacy Advisory Committee was established in 2008 to advise the Board and the Secretariat on global advocacy (ref: Kenefick, H. and Baxter D. (2011) "The Stop TB Partnership Advocacy Advisory Committee Evaluation Report", March 2011). However our consultations suggest that the lack of a clear strategy has been a core issue, despite these attempts.

²² In streamlining the Partnership's role in advocacy and communications, the Operational Strategy also identified activities that were of limited relevance and considered un-impactful and should be deprioritised: (i) the celebrity engagement; (ii) the UN Special Envoy on TB activities; and (iii) the advocacy, communications and social mobilisation (ACSM) workstream.

Committee (SIIC) and the Grant Approvals Committee; advocacy support for the Global Fund replenishment; engagement with the Board and Secretariat on the development of the New Funding Model (NFM) for TB; assistance to countries for their applications for funding under the NFM;²³ and creation of the TB Situation Room (which is a regular forum that brings together all major TB players) designed to increase the disbursement rate of Global Fund TB grants.²⁴ Consultations with Global Fund leadership and operational staff have suggested considerable value in these roles played by the Partnership.

- *Advocacy activities aimed at enhancing efforts towards TB care and control, including raising domestic resources for TB:* Key areas of work of the Partnership include a long-standing engagement with the Southern African Development community (SADC) on an initiative on TB and mining (see Box 4.1) and Ministerial level engagement with the BRICS countries aimed at enhanced cooperation and initiatives towards improving commodity access.

Box 4.1: TB and mining initiative

TB amongst miners in Southern Africa is a regional public health issue: one-third of TB infections in Southern Africa are linked to mining activities and it has been estimated that 3-7% of miners are contracting TB every year. In response to this critical issue, since 2011 the Partnership has been at the forefront of discussions on TB and mining in the SADC to identify and advocate for regional solutions and to raise funds to support this public health challenge. By leveraging the leadership of the Ministers of Health of South Africa, Lesotho and Swaziland, who were members of the Partnership's Coordinating Board, the Partnership has been spearheading the initiative in TB and mining by facilitating meetings of SADC countries, and participating in country missions and high-level ministerial summits. The results achieved under this initiative are presented in Section 5.2.2.

Other issues such as the WHO hosting arrangement have curtailed the Partnership's reach to non-state TB actors in its advocacy efforts – an aspect which is expected to change under the new hosting arrangements.

In summary, the Partnership's advocacy and communication function has faced a number of key issues, however with the development of a new strategy and change in hosting arrangements, the potential for results appears to be more positive.

4.3.2. Partnership-building

Given the structure of the Stop TB Partnership as a collection of partners, convening and engaging with partners is an essential component of the Partnership's work. This function of the Partnership has however been severely constrained by limited availability of resources –

²³ In May 2014, an agreement was signed between the Global Fund and the World Health Organization for the "Provision of Technical Assistance to the Global Fund Applicants under the New Funding Model".

²⁴ As noted in the Stop TB Partnership's Coordinating Board document 1.13-05 "*in line with the operational strategy, the Global Fund represents a major focus of the Partnership's Secretariat's advocacy activities, aiming at supporting Global Fund financing and grant management policies through partner coordination and strengthened community advocate voices*".

indeed, with an expenditure of roughly US\$12m (or 28% of the Partnership's spend on its core activities) in 2009, it has declined to just under US\$3m (or 4%) in 2013.

In recognition of its limited resources, the Partnership has streamlined its work in this area under its new Operational Strategy to focus on: (i) developing its partner base; (ii) strengthening the Working Groups; and (iii) supporting the development of the Global Plan to Stop TB and the post 2015 agenda. In particular, it has de-prioritised its work on national-level partnership-building since 2013 – which has had mixed feedback amongst different stakeholder groups, although the Partnership's donors are more strongly supportive of this change given their view that the Partnership should focus on global-level activities.

Our review of some of the Partnership's work in this area indicates that:

- Over recent years, the Partnership has done particularly well to strengthen its engagement with TB communities and advocates through various approaches, including successive rounds of grants from the CFCS (Annex 7 provides more details), playing an instrumental role in the creation of the GCTA and entering into a Technical Assistance agreement with the Global Fund to support the engagement of community representatives in Country Coordinating Mechanisms (CCM).
- The Working Groups, as a core partnership-building approach, have been fraught with management issues and a number of consultees have questioned the added value of some of the groups (discussed further in Section 4.4.4 below).
- More generally, while the Partnership has been engaging with TB partners through all of its activities (including that of TB REACH and GDF), there is limited clarity on what exactly its “partnership-building activities” are (beyond the Working Groups), suggesting the need to further clarify its role and activity focus in this area. For example, while the Partnership has been continually expanding its member base (see Annex 6 for details), limited resources have implied a limited degree of engagement (primarily through newsletters, website updates and partner consultations).

Therefore, our review suggests that there is a need to better define the partnership-building activities of the Partnership, and in particular, to target limited resources towards clear objectives and intended results.

4.3.3. TB REACH

As agreed with the Secretariat, we have not conducted a detailed review of the TB REACH initiative. In general however, all of our consultations noted the positive role of TB REACH and have highlighted that TB REACH is considered a “real success” of the Partnership.²⁵ The mid-term evaluation undertaken by CEPA in 2012-13 also noted the positive role and performance of the TB REACH initiative. The evaluation rated TB REACH highly in terms of efficiency and

²⁵ Stop TB Partnership (2012) Operational Strategy: 15 June Consultation Workshop.

efficacy, noting that the design of its funding approach generally worked well and its activities were efficiently delivered by a lean Secretariat.

We understand that most of the mid-term review recommendations have been accepted by TB REACH and efforts have been made to improve its functioning in line with these recommendations. Annex 8 provides a summary of the key issues raised and related recommendations as well as how these have been addressed by the Secretariat to date. In summary, we note positive progress particularly in terms of streamlining the application process to reduce burden on TB REACH and countries during the proposal development process, providing funding for local organisations through the creation of a separate ‘small-track’ funding, and leveraging complementary funding from UNITAID for its operations. Key issues remain with regards to:

- *Encouraging the sustainability and scalability of successful approaches.* The new Partnership Strategy recognises the need to “*increase continuity for successful interventions*” of TB REACH. Positive progress has been made in engaging with the Global Fund to support the inclusion of successful TB REACH approaches into country concept notes under the NFM as well as increased number of TB REACH publications to share best practices and lessons learnt. However, ensuring the sustainability and scalability of grants/ approaches remains an ongoing challenge for TB REACH, especially due to its limited resources (financial, staff) in relation to the efforts required to facilitate this.
- *Improving the efficacy of some of its monitoring and operational approaches.* The review recommended the development of a detailed results framework to better track outputs, outcomes and impact; diversify its resource base; and better define the governance role of its Program Steering Group. We understand that these are work in progress, especially on account of the recent change in hosting arrangements from WHO to UNOPS.

Thus in general, TB REACH has performed well, albeit with some key issues requiring continued/ additional focus.

4.3.4. GDF

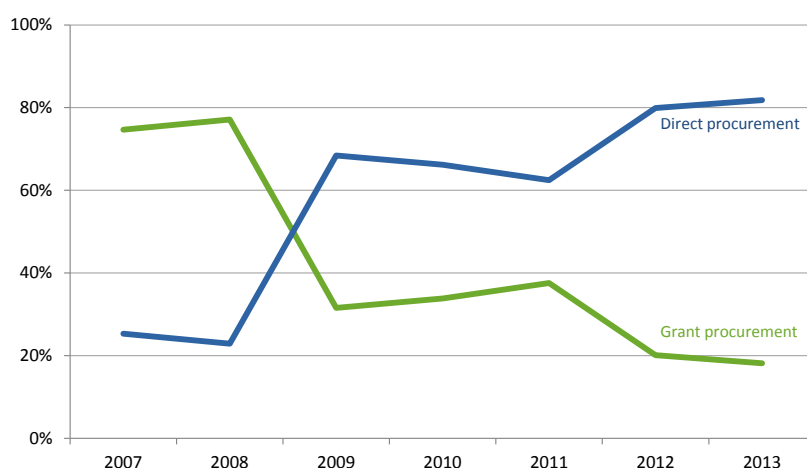
As for TB REACH, we have not conducted a detailed review of GDF. Our review is based on a high-level analysis of previous reviews and evaluations of GDF that have taken place over the period 2010-13 (and as such we have not accessed information prior to 2010).²⁶ This is supplemented by some limited comments provided on GDF during our interviews.

²⁶ Boston Consulting Group (2010) The Future Direction of the Global Drug Facility, Final Report; GDF (2012) Rethinking the GDF”, paper presented at the Stop TB Partnership Board in January 2012; GDF (2012) More than a decade of shaping treatment supply, November 2012; GDF (2013) Improving Access for Quality-Assured TB Medicines and Diagnostics, Update on GDF New Strategic Direction, Presentation to the Stop Coordinating Board Meeting, July 2013, Ottawa; Stop TB Partnership (2013) Global Drug Facility: 6-months of implementing a new strategic framework for 2013-16. Document 1.13 – 12.1 for the Coordinating Board.

As communicated through these sources, we understand that GDF has undergone a critical period of transition, wherein changes in the external environment have necessitated changes in GDF's own functioning. Initially GDF was not adequately prepared for these changes, however since 2013, a new strategic framework has been introduced which is aimed at improving the relevance and responsiveness of GDF.

In particular, increased financing from the Global Fund to countries resulted in a complete reversal of GDF's main service lines from an earlier focus on grant procurement to a surge in demand for direct procurement, as shown in Figure 4.3.

Figure 4.3: Share of TB commodities supplied by service line (2007-13)



Source: GDF data

However, during this change, GDF faced a number of operational challenges including:²⁷

- *Severe staffing and management issues* – for example, the Operational Strategy documents highlight the need for leadership as the most pressing issue for GDF; and there has been high staff turnover over time (25 staff in 2010, 20 in 2011, 15 in 2012 and 16 in 2013);
- *Insufficient attention being paid to GDF systems* resulting in out-dated systems which have limited GDF's ability to respond to the surge in demand;
- *A mismatch between GDF's needs and the procurement agent's capacity to deliver*, which resulted in GDF staff having to undertake additional functions that were the agents' responsibility; and
- *Issues with financial sustainability* – GDF's direct procurement services have been unfunded and subsidised by donor contributions to the grant procurement line. With a decline in the latter, concerns were raised with regards to the financial sustainability

²⁷ Stop TB Partnership (2012) Stop TB Operational Strategy, Summary of July 18-19 Steering Committee Workshop, p. 25, GDF organograms, GDF (2012) Rethinking the GDF, paper presented at the Stop TB Partnership Board in January 2012.

of GDF, especially as it was not allowed to charge for its services under the WHO hosting arrangements.

Following these issues, GDF has been revisiting its strategy and undergoing a process of reform with the development of a new strategic framework in 2013. This framework aims to better structure GDF's work with its comparative advantage and country needs. Box 4.2 presents the key areas of GDF's new strategic framework.

Box 4.2: GDF's new strategic framework

The new strategic framework is centred around four areas of GDF's comparative advantage:

1. **Country support:** GDF is a 'one stop mechanism' for TB commodities and supports countries in strengthening their supply chain management systems through TA, capacity building and monitoring missions.
2. **Market shaping:** GDF plays a key role in keeping manufacturers engaged through global forecasting with the objective of increasing availability and reducing the price of TB commodities.
3. **Changes in GDF operations to maximise impact:** GDF has been evolved from a grant to a direct procurement model and has been adapting its system to better respond to demand by improving linkages with Global Fund and introducing new systems such as the Strategic Rotating Stockpile to reduce lead times for SLDs; Rapid Supply Mechanism, a stockpile of FLDs and SLDs for Global Fund-supported countries facing emergencies; and USAID Flexible Procurement Fund which allows countries to use the fund as a "guarantee" for their direct procurement orders.
4. **Striving suppliers engagement:** GDF has been working closely with suppliers to improve the market for TB commodities; in particular it has shifted from a 'production to order' to a 'production to stock' model and has been engaging with suppliers to increase shelf-life of selected drugs.

Source: GDF's New Strategic Framework (2013)

GDF has also prioritised the hiring and restructuring of staff with the right mix of skills to better fit with its new role.

Stakeholders have commented that the renewed GDF is a step in the right direction, however its role and performance needs to be kept under review, especially with the development of the Global Fund's NFM and its role in global TB funding.

4.4. Governance and management arrangements

This section evaluates the Partnership's governance and management arrangements in terms of their efficiency, effectiveness and transparency. Section 4.4.1 sets out the Partnership structure; and Sections 4.4.2-4.4.4 present our review of the Coordinating Board, Secretariat and Working Groups respectively.

4.4.1. Partnership structure

The Stop TB Partnership is a global movement of almost 1,300 partners, with its organisational structure comprising the following:

- A **Coordinating Board**, with overall governing responsibility, including providing strategic direction and reviewing performance, as well as advocating on the behalf of the Partnership.
- A **Secretariat**, which facilitates the operations of the Partnership and coordinates its members towards achieving the Partnership’s goals. The Secretariat is currently hosted by UNOPS since January 2015, having previously been hosted by WHO.
- **Working Groups**, which are partner-based bodies that have their own organisational structures and hosting arrangements. Working Groups are categorised as either Research or Implementation Groups.
- Three Partnership **initiatives/ facilities** – GDF, TB REACH and CFCS.

Figure 4.4 illustrates the organisational structure of the Partnership.²⁸

Figure 4.4: Organisational Structure of the Stop TB Partnership



Source: CEPA presentation based on “Stop TB Partnership Operational Strategy 15 June Consultation Workshop” document, p.12 and “Stop TB Partnership Basic Framework for the Global Partnership to Stop TB”.

4.4.2. Coordinating Board

A governance review was undertaken in 2011-12, following a recognition that as the Partnership has evolved, its governance procedures (as per the Manual of Procedures adopted in 2004) have become increasingly out of date and the modus operandi of the Board

²⁸ The original Partnership institutional framework included the Partners Forum, which is the assembly of the Stop TB Partnership and consists of an inclusive, consultative meeting of representatives of all Stop TB partners, as well as external representatives invited by the Executive Secretary. One Partners Forum was held during the evaluation period in 2009 and attended by 1,300 delegates. Feedback from consultations suggests that the Forum cost approximately US\$2m and had limited benefits compared to the substantial costs.

has weakened and lacked focus.^{29,30} We present the key issues highlighted, recommendations made and how they have been addressed to date, followed by our summary conclusions on the efficiency and effectiveness of the Board.³¹

Key issues, review recommendations and progress to date

Lack of clarity on the role of the Board in relation to the global TB community and the Secretariat.

Although the core role of the Board has been to oversee and guide the Partnership Secretariat, the governance review identified the need to better articulate the strategic function of the Board, especially in relation to its role vis-à-vis its engagement with the broader TB community. In defining its core purpose, the Board agreed that it has a responsibility: a) to the global TB community to build awareness, facilitate consensus on strategy, and identify key strategic issues affecting TB; and b) to the Secretariat to provide oversight and guidance and to set strategic direction and approve budgets.

This represented a considerable streamlining of the Board's core role, and the Board has since played a much more strategic role, particularly through the involvement of senior Ministers of Health (see for example Section 5.2.2 on TB and Mining). A key issue that has been identified going forward is the ability of the Board to maintain the level of commitment from government representatives, especially with Ministries of Health given high levels of turnover in countries.

An excessively large Board, with the need for more balanced and strategic representation.

Prior to the reforms, the Board consisted of 35 Board members, with certain constituencies being underrepresented. The reforms revised the model of the Board to a constituency-based board with strengthened committees. The Board size was reduced to no more than 28 members, including a mix of rotating and fixed seats, and voting and non-voting seats.

This composition is more aligned with the model of the Partnership as a body representing the voice of its partners.³² Although some suggest that the Board continues to be large, as per Figure 4.5 the size of the Partnership's Board is comparable to those similar partnership-based organisations, such as RBM and PMNCH.

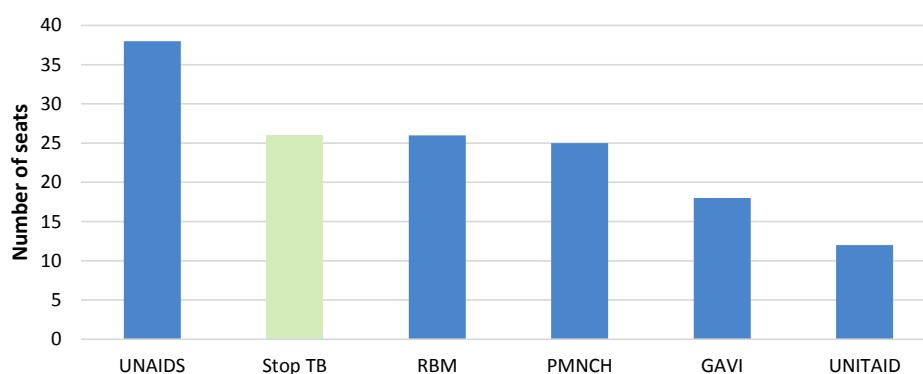
²⁹ Kemppainen-Betram, K., (2011) Review of the Stop TB Partnership Manual of Procedures, p. 1.

³⁰ Stop TB Partnership (2012) "Strengthening the efficiency, effectiveness, and impact of the Partnership Board" – paper presented to the Board on the 8th November 2012, p.4-7

³¹ Stop TB Partnership (2012) "Board Decision Points of the 22nd Meeting of the Stop TB Partnership Coordinating Board", November 2012.

³² The following composition was agreed as per the Governance Manual: 9 fixed voting seats (3 donors, 1 foundation, 2 technical agency seats, and 3 multilateral agencies); 14-16 rotating seats (6 countries, 1 northern NGO, 1 southern NGO, 2 communities, 2 Working Groups, 1 private sector, 1 multilateral, and 2 open seats); and 3 non-voting seats (Chair, Vice-Chair, and UNITAID).

Figure 4.5: Size of Board of comparable partner-based organisations (2007-13)



Source: CEPA analysis of comparator websites and strategic documents

The revised Board composition also includes two open-seats to be filled by new donors or partners. We understand the Partnership has approached potential members, but has yet to formalise who will fill them.³³ Given the strategic nature of these seats it is important that their allocation is prioritised.

Insufficient utilisation of the Executive Committee, with the need for stronger oversight and performance management of the Secretariat, and greater transparency around its discussions and decisions.

The Executive Committee was identified as a key instrument to support the Board; however, the reforms highlighted that there was a lack of standardised processes and communication between the Committee and the Board, which not only weakened the role of the Executive Committee but also impacted on the Board's ability to focus on more strategic/ high-level discussions. The reforms formalised the role of the Executive Committee and established a Finance Committee. Relevant processes were also clarified, which have been agreed and consolidated in the Board Governance Manual (see below).³⁴

A lack of clarity on the expectations of individual Board members and weak transparency surrounding constituency selection processes.

The lack of clear ToR for Board members was identified as a key weakness of the Board, resulting in differences of expectations regarding the level of engagement and time-commitment to Board tasks and meetings. Through the reforms and the development of the Governance Manual, these issues have been codified and systematised.³⁵ In particular, clear roles and responsibilities for all Board members, including time-commitments, have been clearly defined. The Manual also includes a set of required skills and competencies to ensure Board members are adequately selected to represent their constituency and to ensure a high level of board ownership and accountability.

³³ Stop TB Partnership, Teleconference Executive Committee (55 Ex Comm – 16 September 2014) Minutes.

³⁴ Stop TB Partnership (2013) Board Governance Manual

³⁵ Ibid.

Insufficient alignment on the role of the Working Groups and a lack of mutual accountability between Working Groups and the Board.

The reforms identified a misalignment between the role of the Working Groups and their engagement with the Board, in particular the need to: (i) better define role of Working Groups; (ii) better identify opportunities for collaborations between groups; and (iii) provide effective feedback to Working Groups on their scope of work, budgets and strategic issues. The need to formalise communication flows between Working Groups and the Board was also highlighted as a gap.

Although there have been some reforms introduced to strengthen the relationship between the Board and Working Groups, we note that this is an ongoing area of work.³⁶

Inefficient Board meetings, with a need for clearer processes around agenda-setting and decision-making.

Board meeting agendas were identified as being “*complex, overloaded and too technical*”,³⁷ which limited the efficiency and effectiveness of Board engagement. Further, a “*lack of clearly defined processes*” resulted in the Board having to focus on addressing administrative and procedural issues, which were not within their competencies. Thus, it was agreed that the agenda should be structured around key strategic issues where the Board could better provide its inputs. The Governance Manual sets out clear processes for the preparation and documentation of Board meetings, including ensuring that Board members can input into the next meeting’s agenda and guidelines on the decision-making process.

Overall efficiency and effectiveness of the Board

In terms of efficacy, feedback during our consultations indicated that the governance reforms have greatly improved the effectiveness of the Board and their meetings, with greater clarity on roles and responsibilities, improved constituency representation and streamlined procedures/ processes. However, given that these reforms have only been recently implemented, their full impact and any outstanding/ additional issues would need to be reviewed over time.

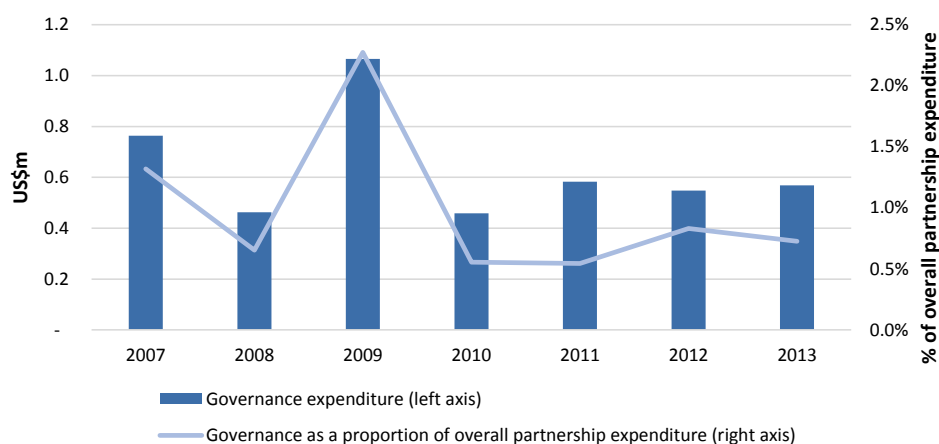
Feedback also indicates that there have been substantial improvements in efficiency of the functioning of the Board with meetings having a clear agenda and specific decision-points. One of the recommendations from the governance review was to reduce the number of yearly Board meetings from two to one, given the Partnership’s resource constraints and the

³⁶ However, the number of Working Groups representatives on the Board has been reduced from seven to two (one to represent the implementation Working Groups and one the research Working Groups). Although the Governance Manual does not detail the relationship between the Board and the Working Groups, it notes that: (i) the Board may establish additional Working Groups, as it deems necessary to carry-out the business of the Board; and (ii) the Board will establish ToR for all new Working Groups and review Working Groups ToRs as appropriate. Stop TB Partnership (2013) Board Governance Manual, p.23.

³⁷ Stop TB Partnership (2012) Strengthening the efficiency, effectiveness, and impact of the Partnership Board” – paper presented to the Board on the 8th November 2012, p.7.

substantial cost of Board meetings. In practice, we understand that Board meetings have been reduced from two per year to one every nine months, to allow for some cost savings. Over the period 2007-13, governance costs have been relatively higher in the earlier years and declined thereafter (Figure 4.6). It remains to be seen if further efficiencies can be secured through the recent reforms.

Figure 4.6: Partnership spending on governance, US\$m (2007-13)



Source: CEPA analysis of detailed Partnership financial reports

4.4.3. Secretariat

The Secretariat has faced a number of issues on account of the lack of a clear structure and defined roles as well as limited resource availability. In particular:

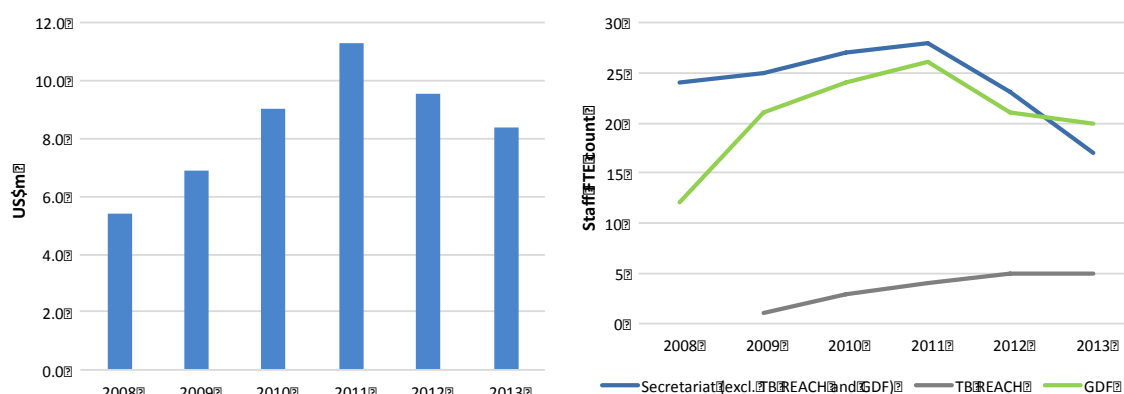
- The Operational Strategy documents note that “historically the core role and functions of the Secretariat have not been defined”.³⁸ Although in the past, attempts were made to streamline the work of the Secretariat, due to high-staff turnover, it is unclear whether these were implemented.³⁹ Thus, the Operational Strategy represents an important development in clarifying the role of the Secretariat and we understand that it has been followed by a team re-allocation to better align with the four areas of focus.
- In line with the Partnership’s resource availability, from 2011 there has been a significant reduction in the number of Secretariat staff (excluding GDF and TB REACH) – which increased from 24 in 2008 to 28 in 2011, before dropping sharply to 23 in 2012 and 17 in 2013 (as shown in Figure 4.7). While some of the reductions have contributed to improved efficiency (especially following the “sun-setting” of certain functions in the new strategy), a number of staff positions continue to be vacant (e.g.

³⁸ Stop TB Partnership (2012) Stop TB Operational Strategy, Summary of July 18-19 Steering Committee Workshop, p. 5.

³⁹ We understand that in 2006 a strategic plan was developed for the Secretariat with detailed objectives, areas of work, and indicators. Ref: Stop TB Partnership (2006) Secretariat Strategic Plan.

seven of a total of 24 staff positions in the 2013 organogram), implying some competency gaps and available staff having to take on additional tasks.

Figure 4.7: Staff costs and numbers, US\$m (2008-13)

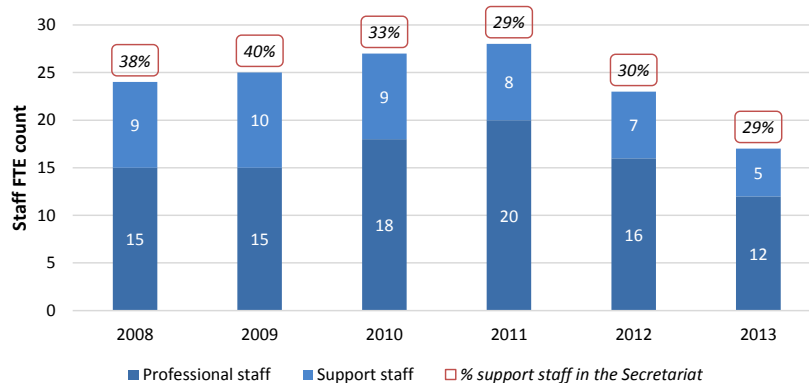


Source: CEPA analysis of Partnership HR data

Notwithstanding these challenges, feedback from the consultations suggests that the work of the Secretariat has been “impressive” given its “skeleton staff”.⁴⁰ Stakeholders view the Secretariat as a whole as being staffed with a well-qualified and professional team, with a passionate leadership that has been key to driving recent reviews and reforms (although some commented that there is a need to “institutionalise” some of the key relationships driving the Partnership’s work).

The Secretariat’s improving efficiency is also reflected in its declining ratio of support to professional staff. In particular we note that the proportion of support staff in the Secretariat fell from 40% to 29% between 2009 and 2013 (see Figure 4.8).

Figure 4.8: Secretariat staff FTE count, by professional and support staff (2008-13)



Source: CEPA analysis of Partnership HR data

⁴⁰ This was also recognised in the Partnership’s Partner’s Survey conducted in 2013, which reported that 73% of partners were either “completely satisfied” or “satisfied” with the Secretariat’s work overall. No respondents reported that they were “completely dissatisfied”. See Survey to Stop TB Partners - 2013 – Final Report, p.12

Furthermore, the share of staff to operational costs for TB REACH and GDF has been improving over time (see Annex 9 for details):⁴¹

- **TB REACH:** From its establishment until the end of 2013, TB REACH’s staff costs totalled US\$3.4m, which represents 4.4% of the funds committed to grants over Waves 1 to 3, suggesting relatively low running costs and a high level of efficiency.⁴²
- **GDF:** Although the ratio of staff cost to GDF procurement value has varied over the years, it has been improving since 2012. In 2013 the ratio of staff to annual procurement value was 1.8% (compared to 2.8% in 2012 and 3.3% in 2011), suggesting increasing efficiency in GDF’s operations.

In summary, despite certain constraints, the Secretariat has in general functioned relatively efficiently.

4.4.4. Working Groups

There are two types of Working Groups – research and implementation focused, as summarised in Table 4.2.

Table 4.2: Working Groups of the Stop TB Partnership

Working Group	Category	Years of operation
New TB diagnostics	Research	2001 – present
New TB drugs	Research	2001 – present
New TB vaccines	Research	2001 – present
DOTS expansion	Implementation	2000 – 12, currently dormant
TB/HIV	Implementation	2001 – present
Global Drug-resistant TB Initiative/ Multi-Drug Resistant Tuberculosis (MDR-TB) Working Group	Implementation	2001 – present, re-named as the Global Drug-resistant TB Initiative in 2013 after consolidation with the Green Light Committee
GLI	Implementation	2008 – present

Source: Stop TB Partnership website

Stakeholder feedback suggests that the Working Groups are viewed as an important component of the Partnership given their role as forums for partner engagement. This view is also reflected during the development of the Operational Strategy, which notes that the Working Groups are “a critical mechanism of the Partnership and are a central platform for

⁴¹ Operational costs refer grant commitments for TB REACH and disbursements for GDF. See Annex 9 for details.

⁴² Although the Wave 4 call for proposals was launched in September 2013, Grant Agreement letters and activities did not start until mid-to-late 2014 and hence has been excluded from our analysis.

partners to coordinate and engage".⁴³ Furthermore, Working Groups also provide the Partnership with access to technical expertise across relevant areas for TB.

However, stakeholders have commented that some of the Working Groups have not evolved alongside changes in the external environment, with groups such as the DOTS expansion group becoming dormant due to their limited value add. The Working Groups in general have faced a number of management and operational challenges which have reduced their effectiveness. In response to these challenges, the Partnership has undertaken an exercise to develop SOPs that would help formalise the structure and processes of Working Groups and increase their effectiveness. As the SOPs have been developed during the conduct of this evaluation, we are unable to comment on their effectiveness, but flag below some key issues and how the SOPs are aiming to address them.

Working Groups have historically lacked clear objectives and structured processes

The 2012 review of the Working Groups noted that historically their objectives have not been clearly defined and that *"it is not clear whether each Working Group has the right goals, how they are decided and monitored and how they contribute to the broader objectives of the Stop TB Partnership"*.⁴⁴ Even though Working Groups have to submit yearly workplans to the Secretariat and the Board, there have been no templates of what should be included or guidance on how objectives should be set vis-à-vis the work of the Partnership and the broader Global Plan goals. Operationally, Working Groups have also lacked clear and consistent governance procedures regarding their creation/ dissolution, as well as the roles and responsibilities of their core groups and Secretariats.

The SOPs propose the development of standardised Working Group structures to facilitate coordination and streamlining of activities (through standardised ToR for the chair/ vice-chair, the core group and Secretariats; criteria for sub-group and task-force establishment; and clear processes for creation and dissolution of Working Groups).⁴⁵

The work of Working Groups has been constrained by severe shortfalls in funding

Over the 2007-13 period, funding to Working Groups has been dramatically reduced due to the overall resource-constrained environment in which the Partnership has been operating. As a result of the sharp decline in funding, Working Groups have had to scale-back their operations whilst also searching for alternative sources of revenues.

To support this challenge of limited funding availability, the SOPs propose a strengthened and more transparent work planning process for the Working Groups, including review, feedback

⁴³ Stop TB Partnership (2012) Stop TB Operational Strategy, Summary of July 18-19 Steering Committee Workshop", p. 12

⁴⁴ The Partnering Initiative (2012) Review of the Stop TB Partnership Working Groups, 23 January 2012, p. 11.

⁴⁵ Stop TB Partnership(2014) Working Groups: Standard Operating Procedures, PPT Presentation, 17 March 2014, p.7

and sign-off from the Partnership Board, to facilitate more effective use of the available resources.

Working Groups have lacked accountability mechanisms resulting in weak and unclear results

The 2012 Working Groups Review identified the absence of a “*formal process for reviewing Working Group/Sub-Group performance against agreed objectives*” as a clear limitation of the accountability of Working Groups.⁴⁶ Although accountable to the Board, like other Partnership bodies, Working Groups have generally only reported on their activities rather than their outputs and outcomes.

Going forward, the SOPs highlight the need for Working Groups to report on a more regular basis and to conform with the same requirements as other Partnership bodies, including the submission of bi-annual progress updates and an annual report supported by feedback from the Executive Committee and focused sessions on Working Groups at Board meetings. The SOPs also seek to strengthen communications between the Working Groups and the Partnership through a range of tools (such as dedicated Working Groups Secretariat focal points, shared online calendar, bi-annual bulletin etc.)

In summary, the SOPs represent an important starting point to define core aspects and formalise key processes of the Working Groups. However, we understand that there has also been limited awareness and discussion on the reforms (as was evident from some of our consultations), suggesting that work is needed to ensure they are applied consistently across all Working Groups.

Summary assessment:

- The Partnership has faced a number of key issues that have impacted its efficiency and effectiveness including lack of a clearly defined strategy, declining financial resources, ineffective hosting arrangements at WHO, and high staff turnover. With the development of the 2013-15 Operational Strategy as well as the change in hosting arrangements, some of these challenges are expected to be circumvented, with the potential for improved performance going forward.
- With regards to the Partnership’s four core areas of work:
 - *Advocacy and communications* activities have historically lacked focus and been constrained under the WHO hosting arrangements. However this area of work is becoming more specific and streamlined following the development of the new strategy, with some early achievements and potential for impact going forward.
 - *Partnership-building* activities need more clarity and definition, but the Partnership has done well in terms of engaging with TB communities.

⁴⁶ Review of the Stop TB Partnership Working Groups, 2012, p.22

- *TB REACH* has been an important success of the Partnership and has made several reforms following the recommendations of the mid-term review. Sustainability and scalability of successful projects is an area that requires continued efforts.
- *GDF* faced a number of operational challenges and was not able to keep pace with changes in the external environment. More recently however it has developed a new strategy with a range of relevant and innovative interventions to ensure responsiveness to the evolving TB landscape and country needs; but this needs to be kept under review to ensure GDF's ongoing relevance.
- The Partnership governance and management arrangements have been subject to recent review and reforms, aiming to improve their efficiency, effectiveness and transparency. This has particularly been the case with the recent Board reforms, although the reforms for the Working Groups are still work in progress and need to be strengthened.
- There has been unanimous feedback that the Secretariat has been impressive, especially in the context of the challenges they have faced such as with regards to limited resources. There is also some evidence of Secretariat efficiency improving over time.

5. RESULTS AND SUSTAINABILITY

This section presents our analysis and findings on the results of the Stop TB Partnership over the period 2007-13. We examine both the overall achievements as well as sustainability of activities and interventions. Our evaluation questions are as follows:

Qs 4: To what extent has the Partnership achieved its mission and objectives, and specifically with regards to: (a) playing a facilitating, catalytic and coordinating role for partners; (b) increasing resource flows to TB; (c) fostering innovation; and (d) progressing the delivery of the Global Plan and contribution to public health?

We examine the M&E framework and approach to reporting of the Partnership as well as available evidence (quantitative and qualitative) on its achievements. We focus on the areas (a)-(d) highlighted in the question and cover the achievements of the Partnership as a whole as well as its three initiatives.

Qs 5: Are the Partnership's activities and benefits sustainable?

We examine the “financial sustainability” of the Partnership, in terms of continued donor funding to support its work and “programmatic sustainability” in terms of whether the Partnership's activities and their benefits have been sustainable (or have the potential to be sustainable).

The section is organised as follows: Section 5.1 provides a review of the Partnership's M&E approach, Section 5.2 presents our assessment of the achievements of the Partnership and Section 5.3 discusses issues relating to sustainability. A summary assessment is provided at the end of the section.

5.1. Review of the Partnership's M&E approach

As a first step to assessing the results of the Partnership, we examine its approach to M&E. We understand that there are a number of elements that guide the Partnership's M&E framework and results tracking, including: donor-specific reporting by the Partnership and its constituent initiatives; the 2013-15 Operational Strategy Strategic Goals and desired outcomes/ metrics; the WHO OSER/ OWER framework; Stop TB Partnership Annual Reports; and additional M&E by the Partnership initiatives including the outsourced M&E for the TB REACH initiative and Key Performance Indicator (KPI) monitoring by GDF.

Our review of these various M&E elements suggests the following:

- **There is a lack of an overarching results framework or logframe that attempts to bring together the various activities and funding for the Partnership as a whole.** There has been an absence of a *unified* results framework to guide and measure the overall achievements of the Partnership as a whole (i.e. a comprehensive framework that encompasses its four core areas of work). Our assessment of the various results frameworks noted above in the context of this assessment is as follows:

- Although the new Operational Strategy is an attempt to outline a unified structure for progress reporting, there is no overarching logframe and the proposed indicators are not detailed or precise enough, as discussed below.
 - Donor specific reporting focuses on the individual donor grants rather than the Partnership activities as a whole. The DFID logframe is a useful results framework but does not encompass the entire Partnership, including its initiatives/ facilities.
 - The WHO OWER/OSER framework include a limited number of indicators and majority of the Secretariat do not actively use this framework for monitoring (as clearly indicated to us during consultations).
- **Existing progress indicators are ambiguous and not directly relevant to the specific activities of the Partnership.** The Partnership’s overall aims have always been noted as work towards supporting the Global Plan. However, given the “downstream” targets of the Global Plan and the “upstream” nature of majority of the Partnership’s work (especially that relating to advocacy and communications and partnership-building), our assessment is that there needs to be greater emphasis on defining more tangible or direct indicators of progress. Although under the new strategy some relevant indicators have indeed been defined, these are not “SMART”⁴⁷ and require clear targets, baselines and milestones in order to enable/ facilitate progress tracking. Some of the donor-specific reporting includes more directly measureable results of the Partnership’s work and are worth building on further to present the Partnership’s progress as a whole.⁴⁸
 - **Excessive focus on activity reporting.** Our review of the Partnership Annual Reports suggests that majority of the reporting focuses on activities conducted/ completed rather than the results of those activities. Annex 5 provides our analysis of the Annual Reports over the period 2007-13 and indicates the limited information provided on results (with the exception of TB REACH and GDF). Although activity reporting is useful, it is not sufficient to track to the achievements of an organisation.

5.2. Partnership achievements

The above-noted issues have impacted the extent to which we have been able to effectively and comprehensively assess the results of the Partnership. Notwithstanding these issues, we present our analysis and findings of the Partnership’s achievements below.

⁴⁷ Specific, Measureable, Assignable, Realistic, Time-related indicators

⁴⁸ TB REACH and GDF have more specific and focused indicators, however these are not presented in the context of a broader framework as noted previously.

5.2.1. Playing a facilitating, catalytic and coordinating role for partners

As described in the 2013-15 Operational Strategy, the Partnership Secretariat has a central role to play in “*facilitating, catalysing, and coordinating partners*” i.e. circumventing challenges to enable something to happen (facilitating), proposing and taking action to lead/spearhead something (catalysing) and bringing relevant entities together efficiently (coordinating).

The key area where the Partnership has played this role is with regards to its engagement with the Global Fund, which bears critical importance given that at present the Global Fund provides almost 80% of external funding for TB globally.⁴⁹ Although the Partnership has been engaging with the Global Fund since its inception, feedback from consultations with the Secretariat, and importantly, the Global Fund and Partnership Board members, suggests that this engagement has become more strategic and impactful since 2011. In particular, it was commented that the Partnership’s engagement with the Global Fund has been “*strong in the past one/two years, whilst it was much weaker before*”, “*probably stronger than any other organisation [working on TB]*”, and that its contribution has been substantial given its size and resources.

Through its strengthened engagement since 2011 some of the Partnership’s key achievements are as follows:

- **Support for increased funding for the Global Fund and its allocation to TB:** Global Fund leadership and TB managers noted that the Partnership has played a key facilitating and catalytic role in: (i) the development of the NFM; (ii) the Global Fund fourth replenishment in 2013, which resulted in US\$12b of pledged resources; and (iii) unified concept notes for TB/HIV in countries with high TB and HIV co-infection rates. Specifically with regards to TB, it was noted that the efforts of the Partnership have contributed to an increased funding allocation for TB from 16% to 18% of the NFM funding allocation for the 2014-16 period; and commitment of a US\$102m regional funding envelope for investments in TB and mining for southern African countries.^{50,51}
- **Ensuring higher and timely Global Fund TB grant disbursement:** Through the establishment of the TB Situation Room, the Partnership has emphasised the need to act on undisbursed funds for TB and supported better coordination of work and sharing of data amongst partners. This has contributed to the disbursement of US\$726m through 130 TB grants in 2013, which was noted as “*the highest-ever amount of funds disbursed for TB*”.⁵²

⁴⁹ <http://www.stoptb.org/global/fund/>

⁵⁰ http://www.stoptb.org/news/stories/2012/ns12_058.asp

⁵¹ http://www.stoptb.org/news/stories/2013/ns13_020.asp

⁵² http://who.int/tb/tbteam/TBTEAMinfoupdate_March2014.pdf

- **Strengthening Global Fund engagement with communities:** Starting in 2012, the Partnership began collaborating with the community constituency at the Global Fund and has been working with communities and CSOs at global and regional levels to strengthen their participation in the Global Fund CCM.⁵³ This support has culminated in the signing of a Technical Assistance agreement between the Global Fund and WHO (on behalf of UNAIDS, RBM and the Partnership) to enable early engagement of communities in the CCM and support them in the development of stronger TB concept notes to the Global Fund.⁵⁴

Thus, in summary, the Partnership's heightened engagement with the Global Fund has contributed to a greater focus on TB with significant contributions in terms of mobilising resources for TB, timely funding for country TB programmes and strengthened engagement with TB communities.

Other examples of where the Partnership has played a facilitating and catalytic role include its work with the GCTA, where we understand that the Partnership was instrumental to the creation of this coalition. More generally however, as noted in Section 4.3.2, the Partnership's partnership-building activities have not been clearly defined, making it difficult to present a summary assessment on their results/ impact.

5.2.2. Increasing resource flows to TB

As outlined in the Operational Strategy, the Partnership has a key role to play in mobilising resources for TB control. In this section we briefly review the TB funding landscape, both in terms of the existing funding gap and the level of support from domestic and donor resources, followed by an assessment of the Partnership's contribution to resource mobilisation for TB. Annex 10 provides more details.

TB funding landscape

Our review of the TB funding landscape highlights the following:

- **Despite increases in domestic and external funding for TB** over the last decade (US\$1.7bn in 2002 to US\$4.4bn in 2011⁵⁵), fundraising for TB has not kept pace with the increasing requirements of the Global Plans, resulting in a **widening resource gap over time** (as shown in Figure 5.1). Moreover, the rate of increase in funding for TB care and control has been lower than for other communicable disease areas – e.g.

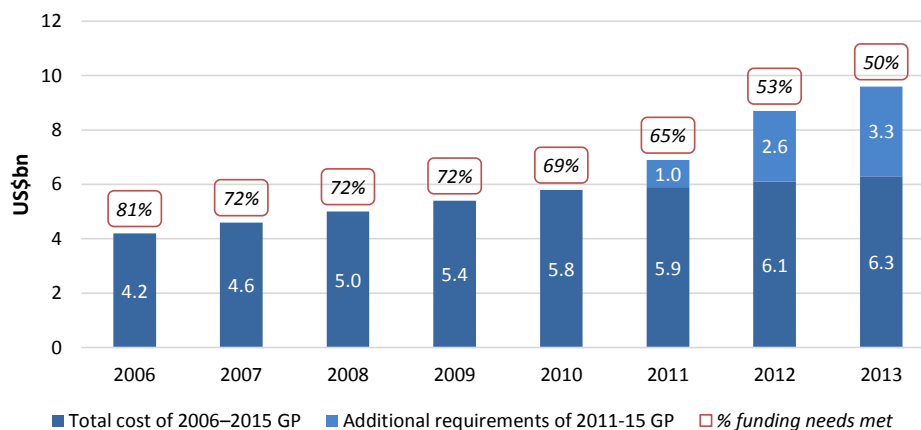
⁵³ For example, undertaking meetings with civil society at the regional level: Stop TB Partnership (2013) Civil Society meeting charts course for increased Global Fund engagement, July 2013, http://www.stoptb.org/news/stories/2013/ns13_052.asp

⁵⁴ <http://www.stoptb.org/global/fund/agreement.asp>

⁵⁵ Floyd, K., Fitzpatrick, C., Pantoja, A., and Raviglione, M. (2013), "Domestic and donor financing for tuberculosis care and control in low-income and middle-income countries: an analysis of trends, 2002–11, and requirements to meet 2015 targets", *The Lancet Global Health*, 1:e105-15.

between 2006 and 2013 the annual growth rate of funding for malaria was 14%⁵⁶, compared to just 5% for TB.⁵⁷

Figure 5.1: Funding requirements for the Global Plans and estimated global funding for TB care and control, US\$bn (2006-13)



Sources: Global Plan to Stop TB 2006-15, p.63; Global Plan to Stop TB 2011-15, p.15; Global Tuberculosis Report 2012, p.53.

- **Domestic funding for TB has been increasing** from US\$1.5bn to US\$3.9bn per year over the 2002-11 period.⁵⁸ The increase in domestic funding has **mainly been in the BRICS countries** (which are also the high TB burden countries) and international donor funding remains crucial for most of the other low and lower-middle income countries.⁵⁹
- **Development assistance for TB grew from US\$0.26bn in 2002 to US\$1.3bn in 2011.**⁶⁰ The Global Fund has been the largest single source of development assistance for TB since its establishment in 2002; in 2011, as per IHME data, it provided over a third of all TB development assistance disbursements (34%). USAID and the Bill and Melinda Gates Foundation are the second and third largest donors respectively, as measured by development assistance disbursements.

Partnership efforts for resource mobilisation for TB

Consultation feedback suggests that the Partnership's activities have supported resource mobilisation for TB, both through its engagement with the Global Fund (as detailed above)

⁵⁶ WHO (2014) World Malaria Report 2014, p.8

⁵⁷ WHO (2012) Global Tuberculosis Report 2012, p.53

⁵⁸ Floyd, K., Fitzpatrick, C., Pantoja, A., and Raviglione, M. (2013), "Domestic and donor financing for tuberculosis care and control in low-income and middle-income countries: an analysis of trends, 2002-11, and requirements to meet 2015 targets", The Lancet Global Health, 1:e105-15.

⁵⁹ Ibid.

⁶⁰ This data has been sourced from the Institute for Health Metrics and Evaluation (IHME) DAH database (2013). It is higher than that presented in Floyd et al. (2013), as it includes additional donors and funding channels which are not covered in the latter.

and also through its targeted advocacy around specific initiatives. We note the following key achievements by the Partnership in mobilising additional funding for TB:

- **TB and Mining:** Starting in 2011, the Partnership leveraged the support of three ministerial TB champions who were part of its Board (the Ministers of Health of South Africa, Lesotho and Swaziland) to advocate for and facilitate dialogue on TB in the mining sector. This resulted in the first ever Declaration by Heads of State on TB being signed in 2012, which led to the launch of two funding platforms specifically for TB and Mining: (i) a US\$102m regional initiative of the Global Fund to provide additional funding to SADC countries (as noted above);⁶¹ and (ii) a US\$100m allocation by the World Bank.⁶²
- **BRICS engagement:** BRICS countries – which collectively account for around 45% of global TB cases – raise more than 95% of their annual TB funding requirements domestically. Indeed, it has been estimated that BRICS and other upper-middle income economies could mobilise almost all of their funding needs to 2015 from domestic sources.⁶³ Within this context, the Partnership has played a key facilitating role in supporting domestic fundraising by bringing together the Ministers of Health of the five BRICS countries and generating momentum, high-level leadership and commitment to cooperation on TB by these countries. This resulted in: (i) the signing of two joint statements in 2013 on their commitment to cooperation for TB care and control: the Delhi Communiqué (January 2013)⁶⁴ and the Cape Town Communiqué (November 2013); and (ii) the formation of a BRICS Technical Task Force on TB and HIV aimed at greater research cooperation on TB and HIV by BRICS countries.⁶⁵ This has been viewed by stakeholders as a key achievement of the Partnership, despite constraints posed by its hosting arrangements.

In conclusion, the Partnership has made important efforts to support resource mobilisation for TB through targeted efforts aimed at engaging with key funding players (such as the Global Fund) and at catalysing high-impact opportunities for resource mobilisation.

5.2.3. Fostering innovation

The main instrument for promoting innovation within the Partnership is the TB REACH initiative, which was specifically set up to in response to the need to go beyond “business as

⁶¹ http://www.stoptb.org/news/stories/2013/ns13_020.asp

⁶² <http://www.worldbank.org/en/news/press-release/2014/03/25/southern-africa-tackles-tb-in-the-mining-sector> and <http://www.observer.org.sz/news/64013-world-bank-global-fund-offer-us-200m-to-fight-tb-in-the-mines.html>

⁶³ Floyd, K., Fitzpatrick, C., Pantoja, A., and Raviglione, M. (2013), “Domestic and donor financing for tuberculosis care and control in low-income and middle-income countries: an analysis of trends, 2002–11, and requirements to meet 2015 targets”, *The Lancet Global Health*, 1:e105-15.

⁶⁴ Ref: <http://pib.nic.in/newsite/erelease.aspx?relid=91533> and http://stoptb.org/news/stories/2013/ns13_003.asp

⁶⁵ Stop TB Partnership (2014) BRICS Technical Taskforce Meeting – Discussion Summary, 31st October 2014.

usual” approaches to TB case detection. CEPA’s mid-term review of TB REACH in 2013 assessed the extent to which the initiative has indeed supported innovative approaches and concluded that: *“The majority of TB REACH grants have supported innovative approaches to case detection, although the extent of innovation has varied by country and grant.”*⁶⁶

The review considered TB REACH innovations in the context of the introduction of a novel approach to a particular setting (rather than a completely novel approach), in line with the broader definition of innovation that is accepted in the public health and development context. Innovations were noted in terms of:

- a first-time introduction of an approach in a country – e.g. introduction of the GeneXpert technology (Wave 1, Pakistan), use of mobile phone-based microscopy technology (CellScope) for automated reading of sputum smear microscopy (Wave 2, Vietnam);
- not being routinely practiced earlier in the country, even though they are often mentioned in the National TB Control manual – e.g. ACF approaches such as contact investigation, use of Public-Private Mix (PPM) models utilising social enterprise solutions for expanding access to GeneXpert testing through private providers (Wave 3, Pakistan); and/ or
- improving access of essential services to otherwise deprived or high-risk population groups – e.g. introduction of TB screening for border immigrants, prisoners, nomadic groups such as the use of a novel combination of traditional horse riders and modern mobile phone technology for sputum collection and dissemination of results (Wave 1, Lesotho).

It was noted that some grants have been more innovative than others. CEPA examined Wave 1 and 2 grants in detail and concluded that approximately 82% of the Wave 1 grants and 68% of the Wave 2 grants qualify as being innovative in the sense described above.⁶⁷ This was also supported by their findings in the country visits where they noted that some projects were repeated across waves (e.g. the GeneXpert technology in Uganda) and others were being previously funded by other donors (e.g. in Kenya and to some extent in Nigeria). Under Waves 3 and 4, a number of innovative projects continue to be funded, with an increasing focus on projects supporting the introduction of the GeneXpert technology, and more recently under Wave 4, for small scale/ grassroots CSOs/ NGOs.

While positively noting that TB REACH has successfully funded a number of innovative approaches to case detection, the mid-term review highlighted challenges in terms of taking

⁶⁶ An e-survey conducted in support of this evaluation confirmed the innovative nature of TB REACH’s projects, with 74% of respondents stating that the initiative has performed well in funding innovative approaches to case detection.

⁶⁷ CEPA covered 28 Wave 1 grants and 35 Wave 2 grants for the purpose of this analysis. The assessment was based on their judgment in defining what is innovative, drawing exclusively on their reading of the project summaries and other documents provided by TB REACH (and appropriately caveated as such).

the innovations forward – both in terms of sustainability and scalability of successful approaches (discussed further in Section 5.3 below) and dissemination of learning from these projects for greater use. We note that the new 2013-25 Operational Strategy for the Partnership, which was developed soon after the mid-term evaluation, accords high priority to these noted challenges.

Furthermore, it has been suggested that although the Partnership’s innovation role has been centred on the TB REACH initiative, there are other Partnership mechanism that could also contribute to fostering innovation in TB care and control. In this context, the Partnership needs to better define and showcase other areas of innovation.

5.2.4. Progress in delivering the Global Plan and contribution to public health

The Global Plan to Stop TB 2006-15 sets the global targets for TB control within the framework of the Millennium Development Goals and the Stop TB Partnership’s goals. The two overarching impact targets are:

- (i) by 2015, the global burden of TB disease (disease prevalence and deaths) will be reduced by 50% relative to 1990 levels; and
- (ii) by 2050, TB will be eliminated as a global public health problem.

These two targets were also maintained in the 2011-15 update of the Global Plan.

Table 5.1 shows that despite positive performance over the past few years, progress towards the Global Plan targets is not being achieved fast enough and performance on some indicators such as those for TB/HIV and MDR-TB lags significantly behind.

Table 5.1: Key TB targets as per Global Plans and progress in 2013

Indicator	Target as per Global Plan	Progress in 2013
1.DOTS Targets	<ul style="list-style-type: none"> • A CDR of 70% is reached • A treatment DOTS success rate of at least 85% in DOTS cohort is reached 	<ul style="list-style-type: none"> • CDR of 64% • Treatment success rate of 86% amongst all new TB cases
2.TB prevalence and mortality targets	<ul style="list-style-type: none"> • Reducing prevalence to 115 or fewer cases per 100,000 population • Reducing deaths to 14 or fewer cases per 100,000 population, including people co-infected by TB/HIV 	<ul style="list-style-type: none"> • TB prevalence estimated at 159 cases per 100.000 population • TB mortality estimated at 16 cases per 100,000 population
3.MDR-TB targets	<ul style="list-style-type: none"> • 100% patients with MDR-TB should be detected and enrolled on SLDs • Treatment success rate should be >75% 	<ul style="list-style-type: none"> • 45% of estimated MDR-TB cases notified and 71% of these enrolled on SLDs • Globally treatment success rate was 48% (cohort 2011)
4.TB/HIV targets	<ul style="list-style-type: none"> • 100% of TB patients should know their HIV status 	<ul style="list-style-type: none"> • 48% of all TB patients globally knew their HIV status

Indicator	Target as per Global Plan	Progress in 2013
	<ul style="list-style-type: none"> • 100% of HIV-positive TB patients should be enrolled on ART 	<ul style="list-style-type: none"> • 70% of HIV-positive TB patients were reported on ART

Source: Targets: Global Plan 2006-15 and Global Plan 2011-15. Progress: WHO 2014 Global TB Report

Measuring the achievements of the Partnership in relation to these goals is challenging because of:

- *The lack of an overarching results framework for the Partnership:* As described in Section 5.1, the absence of a detailed results framework for the Partnership implies that it is difficult to track the specific and totality of contributions to the Global Plan goals.
- *Nature of results:* Given the more “upstream” nature of the Partnership’s activities, it is challenging to link them to the more “downstream” Global Plan results.
- *Work of multiple partners:* Given the role of multiple partners working on TB control, it is difficult to isolate the contribution of the Partnership.

Whilst the Partnership’s advocacy, communications and partnership-building activities would have contributed to the results achieved against the Global Plan targets (e.g. advocacy efforts with the Global Fund have contributed to increased funding for TB which would result in reduced disease prevalence and mortality), we focus here on the more “downstream” and tangible results of TB REACH and GDF towards the Global Plan goals, specifically:

1. Increased number of TB cases detected, as a contribution to the achievement of the Global Plan target 1 on increased case detection rates.
2. Supply of TB drugs as a contribution to the achievement of Global Plan targets 2 and 3 on access to drugs, treatment success rates and reduction in prevalence and mortality rates (although it is recognised that supply of drugs is only one of many contributory aspects to the achievement of these targets).
3. Reduced costs of treatment (including drugs for MDR-TB) to support the sustainability of targets 2 and 3.

Each of these is considered in turn below.

Increased number of TB case detected

Through TB REACH, the Stop TB Partnership has provided funding for innovative approaches to TB case detection. Given that a third of TB cases remained undetected in 2013, TB REACH’s grants provide an important contribution to strengthening case detection.

As per Table 5.2, TB REACH grants in Waves 1 and 2 for which M&E data is currently available have resulted in 38,413 additional Bac+ cases detected (projects in both Waves 1 and 2,

adjusted for historical trends);⁶⁸ and average percentage increase from baseline of 19.95% between Waves 1 and 2.⁶⁹

Table 5.2: Summary of additional Bac+ TB cases detected in Waves 1 and 2 (year 1 only)

Indicator	Wave 1, Year 1	Wave 2, Year 1	Total
Number of projects	29	43	72
Trend adjusted additional Bac+ TB cases [range across projects]	19,050 [4,288 to -424]	19,363 [3,472 to -995]	38,413
Percentage increase from baseline [range across projects]	24.6% [936% to -12%]	15.3% [218% to -16%]	19.95% (average)

Source: TB REACH M&E agency reports

Interestingly, the number of additional cases is only slightly higher in Wave 2, which had more projects (and funding) compared to Wave 1, and the percentage increase from baseline is lower than during Wave 1. As shown in parenthesis, the number of additional cases varies by project, with some projects registering negative additionality (i.e. less cases than at baseline). Nevertheless, consultation feedback from the mid-term evaluation of TB REACH suggested that these numbers “represent a substantial achievement, although [the evaluation was] unable to judge the extent of progress in the absence of specific targets and milestones for TB REACH’s overall results”.⁷⁰

The CFCS has also been an important instrument contributing to increase TB case detection and treatment by supporting TB communities. For example, over Rounds 3, 4 and 5, CFCS grants helped reach a total of 1,170,926 beneficiaries with information on TB and refer 28,554 people for testing (see Annex 7 for more detailed results).

Increased supply of TB commodities

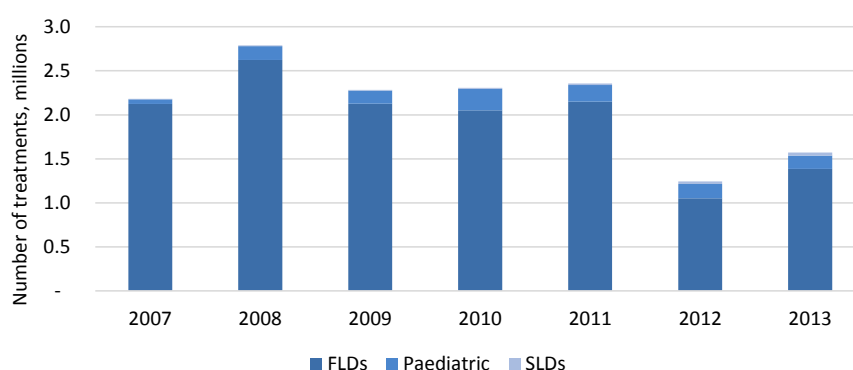
GDF has been supplying FLDs, SLDs, diagnostics and has developed innovative products such as the Stop TB patient kit. Over the 2007-13 period, GDF supplied a total of 14,728,782 patient treatments worldwide. The overwhelming majority of these were FLDs (91.7%), 7.5% were paediatric FLDs and 0.8% were SLDs (as shown in Figure 5.2).

⁶⁸ Additional cases detected is defined by the TB REACH M&E agency as “Trend adjusted additionality: the unadjusted additionality of new and retreatment bacteriologically positive (Bac+) TB cases adjusted by historical trend (i.e. taking into consideration what the evolution of notification was in the evaluation population during the three years before implementation)”.

⁶⁹ Calculated as the number of additional cases notified during implementation over the number notified during baseline.

⁷⁰ CEPA (2012) Mid-term evaluation of TB REACH, page 37.

Figure 5.2: Volume of patient treatments supplied by GDF, millions (2007-13)

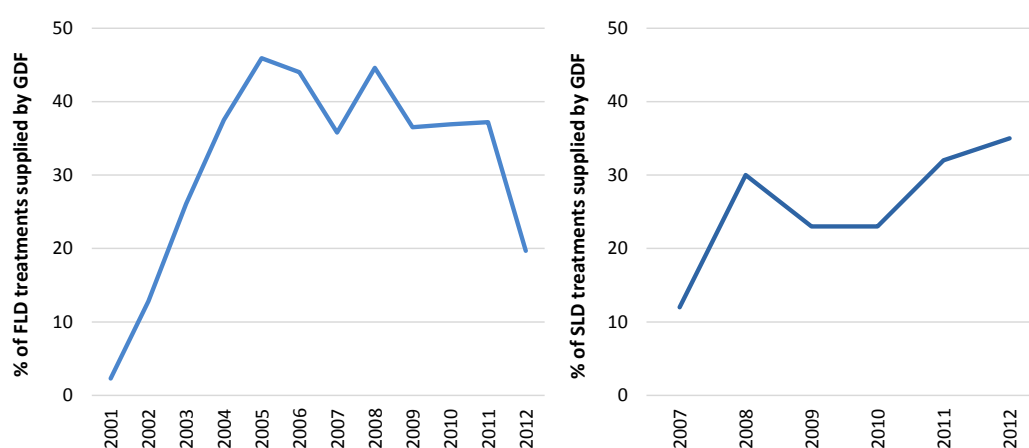


Source: CEPA analysis of GDF data

GDF's market share highlights its contribution to supporting the Global Plan targets. In particular:⁷¹

- GDF's market share for FLDs has declined from 45.9% of notified TB cases in 2005 to 19.7% in 2012. These declines have been on account of the increasing number of untreated patients but also more patients being treated in the public sector with drugs not supplied by GDF.
- GDF's market share for SLDs has been steadily increasing since 2007 (when it first started to procure SLDs) and in 2013 GDF supplied SLDs for 35% of notified MDR-TB cases. As the sole procurer of SLDs for the Global Fund, GDF's market share for SLDs is presently increasing.

Figure 5.3: Share of GDF's market by: (i) FLDs and (ii) SLDs commodities procured (2007-12)



Source: CEPA analysis of GDF data

GDF has also played an important role in strengthening country supply chain management, which would contribute to more effective access to TB commodities. One of the key vehicles

⁷¹ Stop TB Partnership (2013) Improving Access for Quality-Assured TB Medicines and Diagnostics, Update on GDF New Strategic Direction, Presentation to the Stop Coordinating Board Meeting, July 2013, Ottawa.

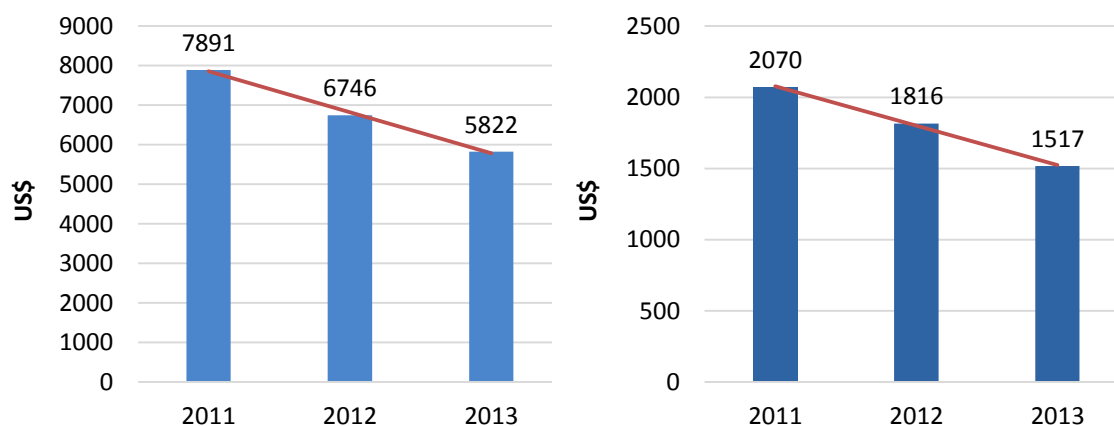
for this are GDF's monitoring missions, through which support is provided to countries on planning for TB drug management.

Reduced costs of treatment (including drugs for MDR-TB)

As a pooled procurement mechanism, one of GDF's roles has been to ensure access to high-quality medicines at an affordable price. GDF has been fulfilling this role by achieving price reductions for a number of FLDs and especially SLDs. A recent report by GDF shows declining prices for FLD and SLD patient treatments when adjusted for inflation, including a correlation between quantities of medicines ordered by GDF and the price of patient treatments.⁷²

In 2013, GDF was able to reduce the price of several SLDs combinations by up to 27% compared to 2011 prices (see Figure 5.4), resulting in a substantial decrease in the overall cost of treatment. This has important public health implications as it allows countries to purchase more treatments (and thus treat more patients) for the same price.

Figure 5.4: Price reduction achieved by GDF for (i) high-end and (ii) low-end treatment, US\$ (2011-13)



Source: CEPA analysis of GDF data

Note: High-end and low-end regimens are sample regimens, as follows: (i) high-end: 12 Cm Pto Cs Mfx PAS/ 12 Pto Cs Mfx PAS; and (ii) low-end: 8 Am Eto Cs Lfx/ 16 Eto Cs Lfx).

GDF has been able to achieve these price reductions through various market shaping mechanisms including competitive tendering process among TB drugs manufacturers; consolidation of orders; and increase in the supplier base for quality-assured SLDs.⁷³ Importantly, GDF has also been able to expand the supplier base for SLDs: in 2013 the supplier base for SLDs was twice as large as compared to 2009 and the number of SLDs products in the GDF catalogue three times higher compared to 2009, resulting in greater supply security for SLDs.⁷⁴ By adding a new supplier to its product catalogue, GDF was also able to achieve a 58%

⁷² GDF Impact on TB Control, November 2012.

⁷³ Stop TB Partnership (2013) March 2013 press release, http://www.stoptb.org/news/stories/2013/ns13_016.asp

⁷⁴ Stop TB Partnership (2013) Global Drug Facility: 6 months of implementing a new strategic framework for 2013-16; Progress Update November 2012- July 2013, p.6.

reduction in the price for Rifabutin.⁷⁵ The various price reductions on SLD treatment regimens between 2011-14 have resulted in savings of US\$21.3m in the first half of 2014 alone.⁷⁶

5.3. Sustainability

We examine the issue of sustainability at two levels: (i) “financial sustainability” of the Partnership, in terms of continued donor funding to support its work; and (ii) “programmatic sustainability” in terms of whether the Partnership’s activities and their benefits have been sustainable (or have the potential to be sustainable).

5.3.1. Financial sustainability

As described in Section 4.2, the Partnership has been operating in a resource-constrained environment with a number of donor agreements coming to an end in 2011-13 and with recent donor funding being highly earmarked for specific activities/ initiatives. The limited and declining donor funding has constrained the Partnership’s work (e.g. it has scaled back its efforts in advocacy, communications and partnership-building; GDF has changed focus from direct procurement to grant procurement) and this is a major challenge for the financial sustainability of the Partnership going forward.

However, we note the following with regards to potential for fund raising for the Partnership:

- *Existing sources:* There has been a core set of donors whose allocations have been consistent over the years (e.g. USAID and DFID have historically provided more than US\$3m/year over 2007-12). For TB REACH, we understand that the current CIDA grant is near exhausted, however there are ongoing discussions on a second grant agreement (along with discussions with other donors as well).
- *New sources:* Through the move to UNOPS, the Partnership will be able to explore new funding opportunities from the private sector as well as other channels such as public appeals and donations from individuals, amongst others.⁷⁷

The current financial status of the Partnership suggests a major risk in terms of financial sustainability going forward unless it is able to attract and diversify its donor base in the near term. It has also been noted that a broader donor base would help to build confidence in the longevity of the Partnership. This will require developing a clear strategy and ensuring adequate resources (human and financial) are allocated to the Partnership’s resource mobilisation efforts.

⁷⁵ Stop TB Partnership (2014) June 2014 Press release http://www.stoptb.org/news/stories/2014/ns14_038.asp

⁷⁶ Stop TB Partnership (2014) USAID Grant to the Stop TB Partnership, Annual Report FY October 2013 – September 2014.

⁷⁷ Annexes to Hosting Review Report (2013), Annex D, p.3.

5.3.2. Programmatic sustainability

The programmatic sustainability of the Partnership's activities varies based on the areas of work. While an in-depth examination is outside the scope of this work, we make the following comments with regards to each of the main areas of work of the Partnership:

- *Advocacy and communication activities:* As discussed in Section 4.3.1, the lack of a structured approach before 2011 suggests that advocacy and communications were undertaken in an ad-hoc manner, which has limited their sustainability. Also, our review of Annual Reports suggests limited "follow-through" of activities, although this may be a biased conclusion due to the limited information and documentation available on the earlier years for our evaluation work.
- *TB REACH:* As noted in Section 4.3.3, the sustainability of TB REACH grants has been highlighted as a key issue in the mid-term evaluation and also during our consultations for this evaluation. Discussions with the TB REACH Secretariat for this evaluation suggest that greater emphasis is being accorded on this; for example "*increase continuity for successful interventions*" has been recognised as one of the objectives under the strategic goal for TB REACH in the new Operational Strategy and has also been included as part of the Technical Assistance agreement with the Global Fund.
- *GDF:* GDF's approach incorporates a number of aspects that are aimed at long term sustainability of its support to countries. For example, GDF aims to act not only as a global procurement platform, but also to support countries to strengthen their supply chain management systems to improve national capacity and support long-term sustainability. GDF also assists countries in planning their transition to other more sustainable sources of funding (whether domestic or donors).⁷⁸

Summary assessment:

- A review of the achievements of the Partnership is constrained by the lack of an overarching results framework that sets out the detailed outputs, outcomes and impacts of all Partnership activities. Partnership M&E is also weak by virtue of not having clearly defined indicators and excessive focus on activity reporting, although TB REACH and GDF have more effective reporting.
- The Partnership has made important achievements in the following aspects:
 - *Playing a facilitating, catalytic and coordinating role for partners* – through strengthened engagement with the Global Fund since 2011, contributing to increased allocation of resources to TB, timely grant disbursement to countries and greater engagement with communities. More generally however, greater clarity in the role

⁷⁸ Annexes to Hosting Review Report (2013), Annex D.

and activities aimed at partnership-building will support better assessment of the achievements of the Partnership in this area.

- *Increasing resource flows to TB* – In addition to work with the Global Fund, the Partnership has contributed to potential additional domestic and regional financing for TB through targeted advocacy initiatives on TB and mining in southern Africa and with BRICS Ministers of Health.
- *Fostering innovation*- The Partnership has played an important role in fostering innovation through the work of the TB REACH initiative.
- *Contribution to the Global Plan* – The Partnership has played an important contributory role to the achievement of the Global Plan targets through increased case detection by TB REACH projects and supply of TB commodities at reduced prices by GDF.
- The financial sustainability of the Partnership faces key risks and there is an important need to increase and diversify its funding base.

6. VALUE FOR MONEY

This section of the report brings together our analysis and findings across the evaluation dimensions of relevance/ comparative advantage, implementation performance, and results and sustainability to conclude on the value for money (VfM) of the Partnership. First we present some thoughts on the approach to assessing VfM (Section 6.1), followed by our assessment (Sections 6.2 and 6.3) and conclusions (Section 6.4).

6.1. Approach

In simple terms, the concept of VfM relates to the value or benefits that an organisation provides in relation to its costs. There are a number of definitions and frameworks proposed for assessing VfM by donor organisations and in the broader literature, for example:

- **DFID** considers VfM in terms of “the optimal use of resources to achieve intended outcomes” and aims to “maximise the impact of each pound spent to improve poor people’s lives”. DFID has adopted a “3Es framework” for assessing VfM comprising: (i) *economy* (quality inputs at the right price); (ii) *efficiency* (quality and quantity of outputs in relation to inputs); and (iii) *effectiveness* (achievement of desired outcomes from outputs), including cost effectiveness (level of impacts achieved in relation to inputs).⁷⁹
- **World Bank** defines VfM as “...the extent to which the programme has obtained the maximum benefit from the outputs and outcomes it has produced within the resources available to it”.⁸⁰
- **Centre for Global Development** defines VfM as “...the relationship between the benefits resulting from programmes or interventions and the resources expended on them”.⁸¹

Thus, VfM aims to ensure maximum benefits for minimum (but yet quality) inputs.

Our evaluation framework has covered a range of questions and analyses that assess the VfM of the Partnership. As such therefore, our approach to assessing the VfM of the Stop TB Partnership is based on our evaluation framework, and specifically, we view the Partnership as providing VfM based on the extent to which it:⁸²

⁷⁹ DFID (2011): “DFID’s Approach to Value for Money (VFM)”

⁸⁰ World Bank (2007): “Results-Based National Development Strategies: Assessment and Challenges Ahead”

⁸¹ Centre for Global Development (2012): “Value for Money in Malaria Programming: Issues and Opportunities” (Working Paper 291).

⁸² We had also planned to review the VfM of the Partnership by benchmarking its performance with other similar partner-centric organisations such as PMNCH and RBM. However, our analysis has been constrained by limited comparable information across the three organisations as well as considerable challenges in drawing meaningful conclusions, not only because of their different overall structures and objectives, but also because of their different approaches in measuring costs. Annex 12 presents a high-level comparative analysis for reference.

- is a relevant organisation, with a core or unique comparative advantage in relation to other global TB players and in response to the needs for TB control (*Evaluation dimension 1 on relevance/ comparative advantage*);
- has been efficient and effective in implementing its activities, with appropriate and well performing governance and management arrangements (*Evaluation dimension 2 on implementation performance*); and
- is delivering on planned results and realising key benefits to support the Global Plan in a sustainable manner (*Evaluation dimension 3 on results and sustainability*).

In the absence of detailed and comprehensive *quantified* benefits and costs of the Partnership (our view is that a mix of qualitative and quantitative information best describes the Partnership’s benefits and costs), as well as an agreed or baseline “benchmark” or “rate of return” to assess the Partnership’s performance, our conclusions on VfM are based on our informed judgement of the relative weights of the various benefits and costs of the Partnership.

We consider the “value” and “costs” of the Partnership in turn below.

6.2. Measuring the “value” of the Partnership

The value of the Partnership can be considered in terms of its underlying relevance and comparative advantage as well as its key results/ achievements to date.

Our evaluation findings on these aspects are as follows:

Relevance and comparative advantage

The 2014 WHO Global TB Report estimates that 9m people developed TB in 2013, and although the disease is fully curable, an estimated 1.5m died from the disease. Of the 9m cases, it is estimated that 480,000 were new cases of MDR-TB; drug-resistant TB is not only a major public health issue but also threatens current and future progress in TB control. TB-HIV co-infection is also a key issue with 360,000 of TB cases also being HIV positive. Given the magnitude of the TB burden globally and the fact that unlike many other diseases there is a cure for TB, the role of the Stop TB Partnership assumes critical importance.

As discussed in Section 3, the Partnership is recognised as an extremely relevant organisation in the TB landscape, especially given its core roles of:

- acting as a convenor/ coordinator of the range of different actors working in TB control, including both state and non-state actors such as communities affected by TB, CSOs and the private sector; and
- the key platform for TB advocacy globally.

This is a unique role that is not played by any other organisation in the global TB landscape and which is highly relevant to meet the current and future needs for TB control.

The Partnership also provides a unique offering through GDF (being a “one stop shop” mechanism for a range of procurement and supply chain support activities) and TB REACH (through its support for innovative approaches to case detection).

The relevance of the Stop TB Partnership was emphasised in all stakeholder consultations for this evaluation, with feedback such as “*the Partnership is a fundamental part of our [the global TB community] response*” and “*if it didn’t exist, it would have to be invented*”. The 2013 Partner Survey also highlights its importance in that an “*overwhelmingly 96% of respondents [to the survey] said that the work of the Secretariat was either ‘very important’ or ‘extremely important’ in the fight against TB*”.⁸³

Key results/ achievements to date

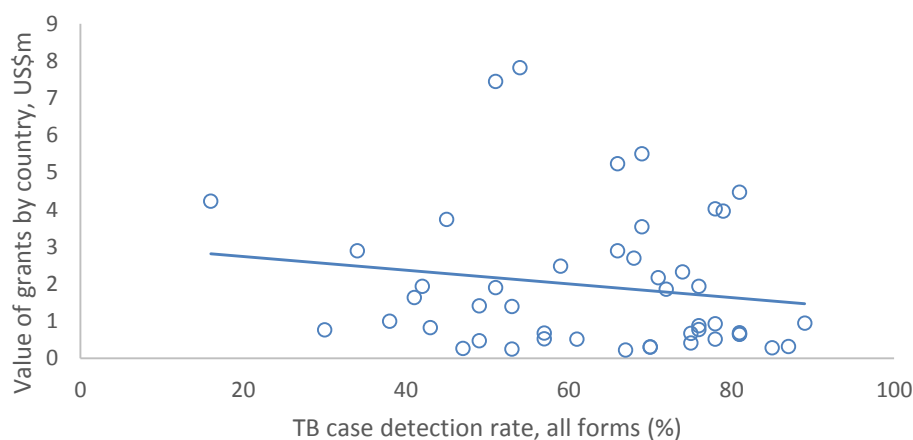
As discussed in Section 5, the Stop TB Partnership has made a number of important achievements over the period 2007-13, contributing to the global efforts against TB. Key results of the Partnership include:

- **Contributing to an increased allocation of Global Fund resources for TB** from a historic 16% to an increased 18% for the 2014-16 period (although some contend that more efforts should have been made to achieve a higher percentage allocation), higher and faster Global Fund TB grant disbursement to countries (US\$726m disbursed in 2013), as well as support for joint concept note for development for HIV-TB funding, which can leverage additional resources for TB and ensure alignment with HIV work programming. These achievements have been on account of a strengthened engagement of the Partnership with the Global Fund, which is critical given that the Global Fund provides almost 80% of external funding for TB globally today.
- **Supporting potential increases in domestic TB resource flows and commitments to TB control and care efforts more generally**, through targeted high-impact advocacy activities with the BRICS countries, resulting in the signing of communiqués for strengthened coordination on TB research and care. The value of this work is reflected in the fact that the BRICS countries together account for 45% of TB cases globally.
- **Contributing to a greater awareness and fundraising for TB and mining in Southern Africa**, through long-standing targeted advocacy and communications in this area, which has facilitated the creation of two regional funding platforms for TB and mining by the Global Fund (US\$102m) and the World Bank (US\$100m). The value of this work is reflected in the fact that mining community in South Africa has the highest rate of TB in the world, with an estimated 3-7% of mine workers developing active TB each year.

⁸³ Stop TB Partnership (2013) Partners Survey.

- **Developing a new Global Plan 2016-20**, bringing together all TB partners through the Partnership’s constituency base and the Working Groups to provide inputs into the Global Plan as the key “road map for concerted global action” on TB.
- **Strengthening the role and engagement of TB communities in various platforms** through: (i) the TA agreement with the Global Fund to ensure greater community representation in Global Fund concept note development of those most affected by the disease; and (ii) continued support to civil society through the CFCS as a key mechanism to raise awareness and support to the local response to TB.
- **Fostering of innovative approaches to TB case detection** through TB REACH grants, where the vast majority of funding (95%) has supported projects in low or lower-middle income countries, with two-thirds of funding being channelled towards projects in HBCs. Further, as shown in Figure 6.1, TB REACH grants have tended to be directed towards countries where the case detection rates for TB are low. Importantly, the focus of TB REACH grants is on increasing case detection and providing access to TB care and treatment to vulnerable, marginalised and underserved populations in high-burden low-income settings; however the sustainability and scalability of successful approaches has been a challenge.

Figure 6.1: Value of TB REACH grants against recipient country TB case detection rate, all forms (%)⁸⁴



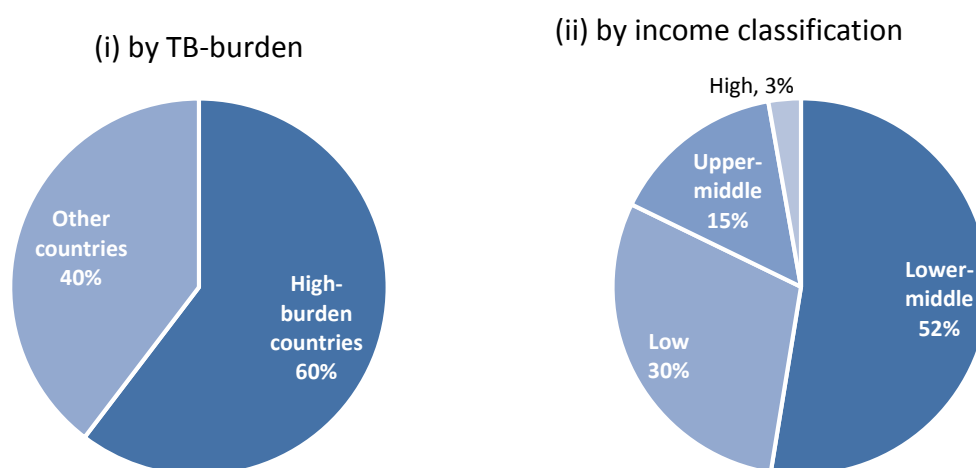
Source: CEPA analysis of TB REACH grants and WHO Global Health Observatory Data Repository

- **Increasing the supply of quality assured TB commodities (drugs and diagnostics) and reducing the costs of TB treatment (especially MDR-TB regimens)**, through the work of GDF which has also helped expand the supplier base for SLDs, contributing to greater supply security. As noted in a recent independent report, “*trends in the costs of second line treatments and first line treatments in low burden countries may be attributed to the role of the Global Drug Facility (GDF) in obtaining competitive prices*”

⁸⁴ Case detection rates are for 2012. Value of TBR grants is the sum over the first four funding waves.

through pooled procurement”.⁸⁵ GDF is the sole supplier of SLDs for all Global Fund grants, magnifying its reach and potential impact in supporting country efforts. The value of GDF’s work is also emphasised through its country focus wherein, as shown in Figure 6.2: (i) 60% of GDF’s procurement spend had been channelled to HBCs; and (ii) lower-middle income countries accounted for more than half of GDF’s procurement over 2007-13 (52%) followed by low-income countries (30%).

Figure 6.2: GDF procurement by (i) TB burden and (ii) country income classification



Source: CEPA analysis of GDF procurement

6.3. Partnership “costs”

In our analysis of Partnership costs, we consider both (i) explicit costs and (ii) implicit costs. These are discussed in turn below.

Explicit costs

We consider explicit costs in terms of the direct or “tangible” costs of the Partnership i.e. its main administrative costs including Secretariat costs, governance costs and WHO programme support costs (PSC). A more accurate measure of administrative costs would also include costs such as Secretariat travel expenses, etc., however we do not have access to sufficiently disaggregated information to present a true picture of the Partnership’s administrative costs. As per Table 6.1:

- **Secretariat costs** (including GDF and TB REACH) have varied substantially over the years, with a slight increase with the creation of TB REACH in 2010, and more generally, highs and lows following availability of donor resources and based on staff turnover. We note that there has been a gradual decline in Secretariat costs since 2011. However the main points that reflect Secretariat efficiency are in terms of a declining support to professional staff ratio from 40% to 29% between 2009 and 2013

⁸⁵ Aidspan (2015) “Examining the trends in costs of medicines for drug-susceptible and drug-resistant tuberculosis from 2010 – 2013; an analysis of Global Fund PQR data”, 14 January 2015.

(as per Figure 4.8 in Section 4) and the overwhelming positive feedback from stakeholders indicating that they have been impressed with the achievements of the Secretariat given their staffing levels.

- **Governance costs** have been generally stable over the years (with the peak in 2009 being reflective of the Partners Forum), although we expect these to be reduced going forward, following the introduction of the Board reforms in 2013 and the shift from two Board meetings per year to one every nine months.
- **PSC** has increased during the evaluation period. Although the Partnership had enjoyed a reduced PSC rate of 7% (3% for GDF commodities), in 2012, the PSC was increased to the standard WHO rate of 13%.⁸⁶

Table 6.1: Administrative costs of the Stop TB Partnership (2008-13), US\$m

	2008	2009	2010	2011	2012	2013
Secretariat costs	5.4	6.9	9.1	11.3	9.5	8.4
Governance	0.5	1.1	0.5	0.6	0.5	0.6
WHO PSC	1.9	1.9	2.9	4.3	3.3	3.3
Total admin costs	7.8	9.9	12.5	16.2	13.3	12.3

Source: CEPA analysis of Stop TB Financial Reports and Stop TB HR data

Further, when comparing the Partnership Secretariat cost with similar organisations, such as PMNCH, we note that the level of expenditures on staff costs is broadly similar: in 2013 the Stop TB Partnership Secretariat comprised 17 staff (excluding TB REACH and GDF) with staff cost amounting to US\$3.5, which is broadly in line with PMNCH’s Secretariat of 12 staff at US\$3m. Additionally as mentioned, up to 2012, the Partnership had benefitted from a reduced PSC of 7%, lower than the standard 13% PSC charged by WHO to PMNCH and RBM (we understand that the actual value of contributions from the Partnership have been the highest amongst all WHO-hosted partnerships).⁸⁷

Implicit costs

We define “implicit costs” in terms of key issues that have impacted the work of the Partnership. These are non-quantifiable in nature and include:

- *Lack of a clearly defined strategy and related M&E framework:* As discussed throughout the report, the Partnership has historically lacked a strategy to guide its operations. Thus, before the 2013-15 Operational Strategy development, Partnership activities lacked focus leading to inefficiencies in the execution of the Partnership’s work. The lack of an explicit M&E framework against which to evaluate its performance has also meant that reporting has been mostly focussed on activities rather than results.

⁸⁶ Hosting Review Report (2013), p.2.

⁸⁷ Stop TB Partnership Board Retreat, Pre read and workshop document, 30 January 2014, South Africa.

- *Hosting arrangements:* Despite the benefits of being hosted at WHO, over the years the hosting arrangement has constrained the Partnership from developing its own identity, resulting in low visibility and confusion with the work of WHO. The Partnership decision to change its hosting arrangement to UNOPS was the culmination of a long and resource-intensive process – first raised at the Coordinating Board in March 2011 and finally completed in January 2015 when the Partnership moved to UNOPS.
- *High staff turnover and vacancies:* Over the evaluation period, there has been high staff turnover and several staff positions have remained vacant for extended periods of time, either due to insufficient funding or the difficulty of filling positions at short notice under the WHO HR system.
- *Issues with Board and Working Group structures and processes:* As discussed in Section 4.4, there were a number of issues with the functioning of the Coordinating Board resulting in the introduction of a series of reforms recently. Further, the Working Groups, while valued initiatives, have been fraught with issues of weakly defined objectives and lack of standardised processes. These are being reviewed at present, with the objective of more streamlined functioning going forward.

6.4. Conclusions on VfM

In summary, the Partnership provides good value by virtue of being an extremely relevant organisation in the global response to TB and having made a number of important achievements including contributing to increased donor (Global Fund) and country efforts/resources for TB, strengthened community engagement in various TB platforms, development of innovative approaches to case detection through TB REACH and increased supply of TB commodities at reduced prices through GDF. The DFID 2013 Annual Review of the Partnership accorded an “A+” scoring to the Partnership; DFID concludes that across the Partnership’s outputs “*most agreed planned milestones for 2013 have been reached or have exceeded the target levels of 2013 milestones*”.⁸⁸

The Partnership’s administrative costs are broadly comparable to that of other similar organisations, and its Secretariat has been regarded as very efficient by a range of its stakeholders. However, the Partnership as a whole has incurred several inefficiencies over the years due to the lack of a comprehensive strategy and M&E framework, several challenges with its hosting arrangements, and high staff turnover. A key risk facing the Partnership is in terms of its financial sustainability following considerable decline in its resource availability.

Recent reforms have been or are being introduced to improve these issues – notably the development of the 2013-15 Operational Strategy, new hosting arrangements at UNOPS and

⁸⁸ DFID (2013) Annual Review - Improving the impact of the UK’s Tuberculosis (TB) – related investments – DFID Support to the Stop TB Partnership 2011-2014.

several governance reforms for its Coordinating Board and Working Groups – with these having considerable potential for more effective working and results in the future.

As such therefore, although in the earlier years of the evaluation period of 2007-13, the Partnership lacked focus and faced increasing costs, in more recent years, it has taken substantial reform efforts to improve its efficiency and effectiveness – and thus represents positive and improving VfM to its donors. Indeed, as commented during our consultations, the Partnership has helped “*put TB back on the map*” and “*sustain the profile of TB, despite all of the other competing pressures*”. As some of the reform process is ongoing/ completed recently, the current period is critical for the Partnership to demonstrate improved VfM and should be reviewed closely.

7. RECOMMENDATIONS

This section provides recommendations for the Stop TB Partnership, based on our evaluation findings and conclusions.

We note that our evaluation has been conducted for the 2007-13 time period, following which major changes have been made at the Partnership, notably the change in hosting arrangements from WHO to UNOPS. As such therefore, some issues/ weaknesses of the Partnership have been/ are being currently addressed and the Partnership has evolved beyond the description provided in this evaluation report. As such therefore, we provide a few key recommendations as outstanding areas requiring further work.

In our presentation of recommendations, we briefly describe the evaluation issue identified, followed by our suggested approach going forward. In terms of approach, we provide high-level thoughts only and do not describe detailed actions required to operationalise these recommendations.

Recommendation 1: Develop a detailed and comprehensive strategy for the Partnership

Our evaluation notes that one of the key issues that has impacted the Partnership's work has been the lack of a clearly defined strategy. While the recent 2013-15 Operational Strategy has been a critical step in this regard, it needs to be further developed and defined.

As such therefore, as the Partnership looks to develop its next strategy from 2016 onwards, we would recommend:

- A clear delineation of the overall goals and objectives of the Partnership as well as a linkage between its activities/ areas of work and the achievement of these objectives.
- A comprehensive strategy that considers its work across advocacy and communication, partnership-building, TB REACH and GDF. While there are a number of donor-specific strategies/ work programmes, our view is that a comprehensive strategy that brings out the work and value-add of the Partnership as a unified collection of several work streams would be useful.
- A description of the Partnership's approach, in terms of "how" it delivers its work, including coordination and alignment with other actors working on TB care and control. Key principles driving the work of the Partnership would also be useful to elucidate.

We understand that the change in hosting arrangements has several implications for the Partnership's work including an enhanced ability to cover a wide-range of advocacy and communication activities, new/ additional operational options for GDF, amongst others. Hence it would be crucial to outline this enhanced/ renewed focus and scope of the Partnership through a clearly elucidated and well-communicated strategy to support a better internal and external understanding and perception of the Partnership.

Recommendation 2: Further define partnership-building and engagement activities

Our review suggests that the Partnership is engaged in a range of partnership-building/engagement activities, however further clarity is needed in its role and activity focus in this area. As such we recommend:

- The Partnership builds on its 2013-15 Operational Strategy Goal 1 on “facilitate meaningful and sustained collaboration amongst partners” which comprises objectives on developing the partner base, Working Groups and the Global Plan and other key global goals and plans. As noted by the Secretariat and other stakeholders during our evaluation consultations, the partnership-building work of the Partnership extends much beyond these objectives and hence these should be better clarified and developed.
- Specific priority activities that represent an appropriate targeting of limited resources should be discussed and agreed (e.g. we understand that the partnership-building with communities and TB advocates is a priority).
- The Partnership plays an active role in searching for partners and maintaining a partner base and hence a clear approach in terms of how to engage with these partners should be determined (also in relation to available resources).
- The Working Groups have been identified as an important institution within the Partnership, but fraught with several issues relating to clarity of goals/ activities and performance. We understand that several reform processes are underway for the Working Groups and it would be critical for the Partnership to ensure maximum use and value from these Groups.

Box 7.1 below provides some information on the activities undertaken by PMNCH to engage its partner base as reference.

Box 7.1: PMNCH’s approach to engagement with partners

PMNCH is an alliance of more than 650 member organisations working in women’s and children’s health. Its comparative advantage is enabling “members to share strategies, align objectives and resources, and agree on interventions to achieve more together than they would have been able to achieve individually”. It has structured its activities around four operating principles, of which the first two are explicitly partner-focused:

- Being partner-centric, by supporting partners to deliver the Partnership’s objectives.
- Focusing on convening by providing a platform for partners to discuss and agree on ways to align their existing and new activities; focus on brokering by actively facilitating knowledge, innovations, collaborations, etc. among its members.

PMNCH has utilised its partner-base in recent years by, for example:

- encouraging global coordination by hosting regular partner-led constituency calls;
- leveraging its convening role to lead global consultations in support of the Global Financing Facility and the Global Strategy for Women’s and Children’s health;
- encouraging coordinated policy resolutions by co-hosting parliamentary meetings; and

- promoting RMNCH accountability by representing stakeholders at the Commission on Information and Accountability, and communicating commitments and progress;

It has aimed to engage with its partner-base by hosting a Partner's Forum in 2014, holding regular partner-led constituency calls and sharing relevant and up-to-date information through knowledge summaries.

Source: Consolidated by CEPA based on the PMNCH website

Recommendation 3: Develop a unified and relevant M&E framework and approach for progress monitoring

Our assessment is that the Partnership's M&E framework and approach is not adequate, especially because there is no single framework that aims to assess the results/ value add of the Partnership as a whole. As such, our recommendations are as follows:

- Develop a unified and relevant M&E framework that maps the inputs and activities of the Partnership's four core areas of work and their results – including the logical chain of events of outputs, outcomes and impacts.
- While impacts, and to a certain extent outcomes, would be determined by factors beyond the Partnership's control and contribution, it would be critical to develop clear and tangible outputs that reflect the direct result of the Partnership's activities.
- KPIs at various levels of results (i.e. outputs, outcomes and impacts) need to be determined. These should be relevant and "SMART".
- An appropriate approach to M&E (e.g. in terms of timelines, types of M&E (routine monitoring or broader evaluation studies), reporting format, etc) should be determined.
- The M&E framework and approach should be well-integrated with individual donor reporting and facility-level reporting (e.g. TB REACH's outsourced M&E agency work) to minimise efforts and resources needed for monitoring.

Such an M&E framework and approach would of course need to be closely linked to the strategy discussed in Recommendation 1 above, and would in fact, form an important component of it.

Recommendation 4: Focus efforts on resource mobilisation for the Partnership's activities

The Partnership has faced declining financial resources including unspecified funding in recent years. The sustainability of the Partnership as a whole is at risk and several of its facilities face financing constraints as well. As such therefore, a key recommendation is for the Partnership to focus efforts on resource mobilisation. Several aspects merit further consideration:

- There is a need to develop a targeted resource mobilisation strategy, with the allocation of appropriate resources as well to ensure its successful delivery (e.g. in terms of FTE of the right skills and capacity for fund raising).

- The strategy would need to consider several aspects/ options for the Partnership such as whether it emphasises resource mobilisation efforts on its existing donors, expands to other new donors (e.g. “emerging” donors from BRICS countries, private sector), etc.
- How should the Partnership balance its role on resource mobilisation for TB as a whole and need for resources to deliver its own activities – options such as the feasibility of a “membership fee” for donor organisations could be explored.