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ASSESSMENT OF THE GLOBAL TECHNICAL ASSISTANCE RESOURCES FOR TB THROUGH THE WHO CONSOLIDATED GRANT

April 2019

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Drs. William Jansen and Maria Miralles.

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ABSTRACT

The USAID grant to the World Health Organization's Global Tuberculosis (TB) program's Technical Support and Coordination (WHO/GTB/TSC) team supports the provision of technical assistance (TA) to 54 priority countries that constitute the majority of global TB, TB/HIV and MDR-TB burden and the majority of Global Fund (GF) TB funding. Out of these 54 countries, 30 do not have USAID bilateral TB funding. In 2017, WHO/GTB/TSC moved from providing TA "on demand" to a more strategic technical assistance planning process.

The purpose of this assessment is to review and assess progress made in the 30 priority countries. The assessment addresses four questions: (1) Have the various models of TB TA provision been designed and delivered in a way that result in maximum results; (2) Have these models been responsive to client needs; (3) Have these models been efficient in terms of process; and (4) Have the effects of TB TA been measurable, and has the process of monitoring TB TA provision been optimal?

The assessment team used qualitative data collection methods and analysis methods, including document reviews, an online survey, and in-person and remote interviews,

Key findings are that TA is designed and implemented by the WHO/GTB/TSC is achieving important results, although there is interest in making use of longer-term TA models as countries increasingly focus on implementation of newly developed strategic plans. The assessment also finds that the highly inclusive approach to identifying and addressing TA needs has been largely responsive to client needs at the national, regional, and global levels. The WHO/GTB/TSC effectively employs a proactive communication strategy to ensure that stakeholder needs are understood and that information on TA progress is appropriately shared. The assessment determined that some important efficiencies exist and that there are meaningful on-going efforts to achieve additional efficiencies. Finally, the assessment team found that the effects of TA are measurable and have been measured, although there is an opportunity to develop a framework to support more outcomes-oriented monitoring and reporting.

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ACRONYMS

DDL	Data Development Library
GF	The Global Fund
GHPro	Global Health Program Cycle Improvement Project
GTB	Global TB program (WHO)
HIV	Human immunodeficiency virus
HQ	Headquarters
ITP	GF Implementation through Partnership
KII	Key informant interview
KPIs	Key Performance Indicators
LTTA	Long-term technical assistance
M&E	Monitoring and evaluation
MDR	Multi-drug resistant
MTTA	Medium-term technical assistance
NSP	National strategic plan
NTP	National TB program
PMDT	Programmatic management of drug resistant TB
RR/MDR	Rifampicin resistant/multi-drug resistant
S/GAC	State/Office of the Global AIDS Coordinator
SFOAA	State, Foreign Operations and Related Programs Appropriations Act
SOW	Scope of work
STTA	Short-term technical assistance
TA	Technical assistance
TB	Tuberculosis
TME	Tuberculosis Monitoring and Evaluation
TOR	Terms of reference
TSC	Technical support and coordination
UNOPS	United Nations Office for Project Services
USAID	United States Agency for International Development
USG	United States Government
WHO	World Health Organization

I. INTRODUCTION

This assessment occurred at about the mid-point in the implementation life of the current grant to the World Health Organization (WHO) for the provision of technical assistance (TA) for tuberculosis (TB) control programs in United States Agency for International Development (USAID) priority countries. Although the work of the assessment began toward the end of December 2018, the initiation of in-person meetings with USAID staff was delayed by a partial U.S. Government (USG) shutdown. Consequently, in-brief sessions and the commencement of most information-gathering activities for the assessment did not begin until February 2019. The remainder of the assessment was conducted from February to May 2019.

ASSESSMENT PURPOSE

USAID has been providing support to WHO's Technical Support Coordination team (WHO/GTB/TSC) since 2007 to help make Global Fund (GF) TB grant implementation successful. Over time, in 2017, the scope of work (SOW) for WHO/GTB/TSC shifted from providing on-demand support to all eligible countries to a more focused approach to support a smaller set of priority countries. The smaller set of countries represented countries where USAID does not have an in-country presence for TB assistance, and a greater in-country TA focus on strengthening laboratory systems, scaling up multi-drug resistant (MDR) TB treatment and care, and support for national strategic plans development and implementation.

The intent of the assessment is to:

- Review and assess progress made in the priority countries, in terms of GF TB grant implementation and disease outcomes
- Determine whether or not shifts in implementation have led to improved GF TB grant performance, greater client satisfaction, and programmatic efficiencies
- Inform future TA activities supported through the TSC mechanism.

The findings of this assessment may also inform the direction of future USAID support (from the GF TA 5 percent) under the TSC mechanism. Findings may highlight best practices or lessons learned through implementation, as well as identify challenges and potential solutions to some of these which could be used in future implementation efforts.

The primary audience for this assessment is the USG, in particular, USAID's TB Division in the Bureau of Global Health and other USG agencies involved with GF TA. Secondary audiences include the GF, WHO, National TB programs, and other bilateral/multilateral GF TA providers.

ASSESSMENT QUESTIONS

The SOW for the assessment of implementation under the consolidated grant to WHO/GTB/TSC is provided in Annex I. The SOW includes four questions for the assessment to address:

1. Have the various models of TB TA provision been designed and delivered in a way that result in maximum results?
2. Have these models been responsive to client needs?
3. Have these models been efficient in terms of process?
4. Have the effects of TB TA been measurable, and has the process of monitoring TB TA provision been optimal?

II. GRANT BACKGROUND

As the largest investor to GF, the USG is committed to supporting successful implementation of HIV, TB, and malaria GF grants at the country level. Since 2005, the Department of State, Foreign Operations, and Related Programs Appropriations Act (“the SFOAA”) has authorized the U.S. Global AIDS Coordinator (S/GAC) to withhold up to 5 percent of the aggregate amount of the USG’s contribution to the GF to be “made available to USAID for technical assistance related to the activities of the Global Fund.”

The USG is the largest bilateral donor in the global TB effort; it works closely with the GF to leverage its bilateral resources and expand the geographic reach of its bilateral TB programs. Close coordination with the GF is an integral part of the USG’s comprehensive partnerships and is outlined in the USG Global TB Strategy. GF grants and USG bilateral TB activities complement one another to address both financial and technical gaps identified in national strategic plans developed by National TB Programs in recipient countries. The USAID TB Program leads USG international TB control efforts and has responsibility for and exercises oversight over U.S. foreign assistance resources and activities for the international TB response. Global Fund 5 percent TA support contributes to the outcomes of the overall USG Global TB Strategy.

USAID’s approach for TA for TB specifically focuses on prioritizing countries with the greatest burden of TB and the majority of the GF TB resources through: an analysis of barriers, the identification of approaches to address them with quality TA, and close coordination with partners to ensure there is no duplication of effort. The approach also includes the utilization of long-term TA (LTTA) to build capacity in the countries with greatest need, especially for the scale-up of quality MDR-TB programs.

In FY 2013, USAID worked closely with WHO/GTB/TSC to shift the approach for TA to prioritize a set of 41 countries covering more than 70 percent of the GF TB grant funding and more than 80 percent of the TB burden in GF TB grants. This shift focused on more proactively identifying TA needs and moving away from “emergency response” to needs in the countries with the highest burden/GF funding. USAID also moved away from supporting Regional WHO/GTB/TSC Coordinators and regional workshops that focused on higher level issues related to TB policies and strategies, and instead moved to ensure that more focused support was placed on implementation concerns at the country level. This focus supported countries through the GF’s “new funding model,” which was rolled out in 2014.¹

In 2014, the Stop TB Partnership shifted its hosting arrangement from WHO to UNOPS. Given that the WHO/GTB/TSC Secretariat was based at WHO, the Secretariat remained within WHO under the Global TB Program. USAID shifted its funding for this mechanism from the Stop TB Partnership Grant to the WHO Consolidated Grant. WHO/GTB/TSC works in close collaboration with the other five GTB technical teams (Research for TB Elimination; Policy, Strategy and Innovations; Diagnostics and Drug Resistance; TB Monitoring and Evaluation; TB/HIV and Community Engagement) and the WHO regional and country offices.

Since 2014, WHO/GTB/TSC has maintained its focus on providing TA to a set of priority countries. Currently for USG, there are 54 priority countries that make up more than 90 percent of the GF TB

¹ The Global Funds’ New Funding Model. April 2013.

https://www.theglobalfund.org/media/1467/replenishment_2013newfundingmodel_report_en.pdf?u=6364868073600000

funding and more than 80 percent of the GF TB burden. Out of these 54, WHO/GTB/TSC provides support for 30 countries that do not have USAID bilateral TB funding. Countries with bilateral funding utilize their funding to address GF-specific issues. Consequently, WHO/GTB/TSC has minimal engagement with these countries.

Of particular note, in 2017, WHO/TSC moved from providing TA “on demand” to a more strategic TA planning process. USAID works closely with WHO/GTB/TSC to prioritize TA needs identified by countries. Once TA is provided to countries, WHO/GTB/TSC carefully reviews the TA to determine what, if any, follow-up is needed and ensure that TA activities complement and build upon each other. WHO/GTB/TSC also works closely with their priority countries to ensure successful implementation of new GF TB grants.

III. ASSESSMENT METHODS AND LIMITATIONS

EVALUATION APPROACH AND PROCESS

The Global Health Program Cycle Improvement Project (GH Pro) assembled an assessment team composed of two consultants and two GH Pro staff members. Dr. William Jansen, the team leader and assessment specialist, provided oversight in the design of the assessment approach, data collection, analysis, and report writing. Dr. Maria Miralles, the TB specialist, participated in all aspects of the assessment (including assessment planning, data collection, analysis, and report writing) and provided input on assessment issues, such as method selection, development of data collection instruments, protocols for data aggregation, data management, and quantitative and qualitative data analysis.

The team utilized a rapid appraisal approach to the assessment, applying multiple techniques to systematically collect and analyze data. The methods for data collection included program document reviews, key informant interviews (KIIs) (face-to-face, or by telephone or Skype, as needed), small focus group discussions, and an on-line survey.

The team performed various analyses to help answer the assessment questions set forth in the SOW, including a cross-country comparison of documented TA needs and subject-matter areas covered in planned or delivered TA efforts. Interview guides, designed to collect similar information from informants in different informant categories, were utilized. The collection of data in similar subject areas facilitated the identification of common patterns or trends. As potential patterns or trends emerged, the team initiated additional, follow up in the form of probing questions with selected informants to verify or clarify the presence of observed patterns.

The team conducted KIIs in person or over the phone or through Internet applications (such as Skype). Both members of the assessment team conducted all interviews. Some interviews were with a single informant and others were in the format of a group discussion.

When possible, the assessment team cross-referenced the data (the application of different data collection methods or the application of one method among different groups of informants) to identify assessment findings. Cross-referencing helped orient qualitative data around recurrent patterns or themes while also serving as a check on the validity of findings from any single information-gathering method or source. The team also examined key functions and processes followed by WHO/GTB/TSC in the design, planning, and implementation of TA to identify best practices and opportunities for improved efficiencies.

SAMPLING AND INFORMANT CATEGORIZATION

After document reviews and after in-brief discussions with USAID/Washington staff, the assessment team grouped key informants into five categories: USAID/Washington TB team leadership and country backstops, WHO TSC staff, GF portfolio managers, Country TB Program staff, and other global TB stakeholders. Persons within the categories became individuals or groups of informants to interview. The categories of informants represented vital data sources for the team to help answer the four assessment questions. A breakdown of the informant categories is included in the assessment matrix (see Annex II).

The assessment team coordinated with USAID and WHO/GTB/TSC to develop a list of potential key informants to be interviewed or surveyed. Suggestions from USAID and WHO/GTB/TSC staff also assisted with the selection of a sub-sample of TA-assisted countries for phone interviews with in-country TB program staff. Figure I summarizes the range and number of interviews (in person or by phone) conducted during the assessment. The list of key informants is provided in Annex III.

Figure I. Informant Categories, Examples, and Numbers Interviewed

Key Informant Categories		
Category Type	Examples of Informants within the Category	# in Category Interviewed
<i>USAID/Washington TB Team</i>	Leadership, country back-stops, technical content specialists	7
<i>WHO/GTB</i>	TSC unit staff, GTB leadership, GTB technical staff	15 (includes some who were not formally interviewed)
<i>Country-Level TB Program</i>	National TB Program (NTP) managers, NTP technical advisors	7
<i>Global Fund</i>	Portfolio managers, program assistants	14
<i>Implementing Partners/Other Stakeholders</i>	Expertise France/Initiative 5% staff, The Union staff, Stop/TB staff, Global Drug Facility staff	9

SITE VISIT

The assessment team traveled to Geneva to conduct face-to-face interviews with WHO/GTB/ TSC, the GF, and other global TB stakeholders. WHO/GTB/TSC staff helped set up appointments with informants both within WHO and externally. While in Geneva, phone interviews were also conducted with six country-level national TB program (NTP) managers and their staff. Phone interviews were held with NTP offices in Burkina Faso, Chad, Cote d'Ivoire, Liberia, Mali, and Niger. Often, the team was able to interview GF staff who backstopped the same countries where NTP managers had been interviewed by phone. The site visit extended over a period of two weeks.

DATA COLLECTION TOOLS

The assessment team developed and utilized a range of data collection tools. These included:

- *Interview Guides:* The team developed interview guides for use with USAID/Washington TB staff, WHO TSC staff, GF portfolio managers, and selected NTP managers. The guides were used to collect similar information from various informants and points of view concerning the TA experience for country-based TB programs. Each interview guide contained questions designed to solicit the information needed to answer the four questions in the assessment SOW. The interview guides for each key informant group are included in Annex IV. Even though the data

collection tools contain common sets of questions posed to informants, the team's interview protocol allowed for additional probing questions to be added during sessions with informants. Similarly, if an informant offered additional information or volunteered other data (not in response to specific questions but relevant to the scope of the assessment), the interviews captured this information as well.

- *Online Survey:* The assessment also utilized an online survey for country TB program managers. The survey focused on NTPs' experience with TA planning and implementation. Survey questions were primarily multiple choice and close-ended. Questions asking for responses based on a Likert scale were also used. The set of questions for the on-line survey is included in Annex IV. One survey question was added after information gathered during some of the KIs suggested another question could yield more data relevant to the assessment. Individualized invitations to participate in the survey were sent via email to TB program managers in all 30 countries of priority for the grant. Each invitation email listed some of the recent TA events conducted in the country to provide the respondent with specific implementation reference points for grant-funded TA.
- *Comparative Tabulation of Gathered Data:* Excel spreadsheet tables were used to help list and compare data on TA (from country TA plans, TA and monitoring reports, interviews, etc.). These tables supported sorting and organizing data to facilitate analysis. Examples of data spreadsheet tables are also included in Annex IV.

ANALYTICAL APPROACH

Analyses of the collected data were oriented to identify repeating patterns or trends evident in informant responses. Qualitative data from the interviews were compared across informants, both within the same informant categories and across categories, to determine patterns and or common trends. Similarly, responses to the on-line survey were analyzed to determine common patterns and then compared with the patterns identified within the other collected data. Part of the analytical work was secondary, such as the case with the information contained in available TA plans, country profiles, project reports, and background documents.

Patterns were identified across all data collected and linked to specific assessment questions. However, patterns observed in data gathered for each assessment question helped inform the interpretation of data related to other analysis of the information obtained to answer the other assessment questions. For example, patterns observed in the design of TA models (Assessment Question #1) helped to understand aspects of efficiencies in the process of TA provision (Assessment Question #3).

ASSESSMENT MATRIX

The team adapted a version of GH Pro's matrix used in evaluations to organize and develop its approach to the assessment approach, key informants, and information-collection tools. The resulting assessment matrix helped to align methods and tools to specific assessment questions. More than one method was used to obtain the information needed to answer each question in the assessment SOW. For each of the assessment questions, the matrix lists the sources of data or information, source selection, and types of information-collection tools envisioned for use (see Annex II).

LIMITATIONS

To answer the questions contained within the assessment SOW, the team faced some methodological limitations. For example, given the various analytical models for efficiency that exist and the limited range of data types the team was able to access or gather within the time available for the assessment, the efficiency-relevant factors examined were limited to the process and time factors related to overall efficiency in the provision of TA. The team did not have access to cost data and cost was not a factor or variable included in the assessment's analysis of efficiency.

For phone interviews with country-level stakeholders, finding times when informants could be available was sometimes difficult. Some phone interviews involved the use of a translator when the respondent(s) were not comfortable answering questions in English. Poor phone connections also occasionally complicated interviews when calls were dropped and phone contact had to be reconnected.

The use of an online survey offered the strength of providing an opportunity to obtain some information from national TB program stakeholders in all of the 30 countries defined as a priority by USAID. However, as is the case with any voluntary survey, the response rate is not guaranteed to be high. Potential language barriers to obtaining responses were addressed by having the survey translated and available to respondents in French, Portuguese, Russian, and English. In addition, the assessment team anticipated the need to send reminders to non-responsive survey participants to achieve the highest response rate possible. The reminders were sent at the middle of the planned survey response period.

Even with the reminders, at the end of the planned survey period, only 12 of the invited 30 (40 percent) country NTP representatives had responded. The survey period was then extended and another set of reminder emails was sent to the 18 NTPs that had not responded. At the end of the extended survey period, only three more country NTPs had responded, yielding a final response rate to the online survey yielded of 50 percent. Country NTPs that did respond included: Azerbaijan, Belarus, Burkina Faso, Central African Republic, Chad, Georgia, Guinea, Kazakhstan, Liberia, Morocco, Niger, Pakistan, Rwanda, Senegal and Sierra Leone.

IV. FINDINGS

Information-gathering for the assessment focused on TA activities undertaken during the implementation period from 2016 until the end of 2018. The assessment team identified patterns and trends that characterized the TA efforts undertaken under USAID's grant to WHO during this same period. The countries receiving TA and support through this grant submitted funding proposals to the GF in 2017 and 2018.

Findings from the work of the assessment are grouped and presented below by each assessment question. Any conclusions or identification of opportunities for improvement related to the assessment questions are also included in the sections related to the relevant question.

ASSESSMENT QUESTION 1: HAVE THE VARIOUS MODELS OF TB TA PROVISION BEEN DESIGNED AND DELIVERED IN A WAY THAT RESULTS IN MAXIMUM RESULTS?

FINDINGS

The five objectives listed in the SOW for USAID's grant to WHO/GTB/TSC (see Box 1) are all related to the provision of comprehensive TA support for priority countries to enable the successful implementation of GF grants (including specialized TA for MDR-TB programs and diagnostics). These objectives are also consistent with the GF's Partnership Strategy to support achievement of high impact results for country programs.² Important elements of this strategy include TA for varied aspects of the grant application and implementation process, facilitating greater harmonization and alignment in accordance with the USAID effectiveness agenda, mobilizing resources to support health programs, and facilitating effective communication and information-sharing. A sharper focus on the provision of support to national strategy planning processes and to strengthening local capacity and monitoring are emphasized in the 2017-2022 GF Partnership Strategy document.³

Due to changes in the context of current TB priorities, the fifth objective no longer applied. Consequently, the team examined the types of TA utilized, as well as their design and delivery, in terms of the results achieved or progress realized programmatically or in relation to the active objectives contained in the grant to WHO.

The designs for TA currently utilized by WHO/GTB/TSC are the product of experience gained from providing support to country-level TB programs over several years. Processes utilized for the design of TA are collaborative and actively engage a wide range stakeholders at a variety of levels. WHO/GTB/TSC develops TA approaches, involving in-country NTP managers as well as WHO TB staff at the regional and country levels.

² https://www.theglobalfund.org/media/3815/bm20_04policyandstrategycommittee_attachments1to4_en.pdf

³ Global Fund. 2018. https://www.theglobalfund.org/media/2531/core_globalfundstrategy2017-2022_strategy_en.pdf.

TA plans are based on the TB program needs identified in specific country profiles. For example, the 2018 country profile for Liberia identified a need to facilitate the uptake of the diagnostic algorithm

Box I. USAID Grant Objectives

1. To support global level coordination related to GF grant implementation and the provision of comprehensive TA in coordination with USAID based on a thorough assessment of needs.
2. To support the provision of TA while building the capacity of national stakeholders (e.g., NTP) to effectively implement GF-financed activities. This includes reviewing and analyzing the provision and quality of technical assistance and monitoring TA reports to determine if there are further needs and regularly monitoring country-specific TA plans to ensure the effective implementation of a country's national TB strategic plan.
3. To support the provision of comprehensive TA for the preparation of GF new funding applications aligned with TB national strategic plans.
4. To provide technical support to ensure the successful implementation of TB prevalence surveys, drug-resistance surveys, and standards and benchmarks.
5. To address TB issues related to the GF Implementation through Partnership (ITP) initiative in five countries.

developed by the NTP in association with the deployment of 20 GeneXpert machines. Accordingly, the 2018 TA plan for Liberia included a two-week TA activity by an international expert to advise on the placement of the 20 machines to maximize access and to update GeneXpert testing.

WHO/GTB/TSC works closely with USAID, the GF, national TB programs, WHO regional and country offices, and technical partners to complete needs assessments of countries through the joint development of country profiles. These profiles are used as a basis for the development of prioritized TA plans. TA program needs are updated at least annually (sometimes more frequently) and are reflected in revised country profiles. Information gathered from country-level NTP staff (by phone interviews and through the on-line survey) show that NTP personnel feel that the techniques used by WHO/GTB/TSC lead to a very good understanding of country needs. WHO/GTB/TSC utilizes a consultative process, involving NTPs in a “country-driven” approach, to develop TA plans.

TA approaches are also closely coordinated with the GF as well as other technical and financial partners. These stakeholders are involved in the analysis of TA needs (including the development of country profiles) as well as in the identification of priorities for the provision of TA. In addition, the prioritization of TA is the product a consensus-based approach for determining the most important areas needing attention for a country TB program.

Once collectively identified, TA needs are matched with available funding sources and appropriate expertise to address those needs. Designs of specific TA interventions include technical reviews by in-house WHO subject matter experts, both at HQ and the corresponding regional office, who examine consultants' terms of reference (TOR), TA reports and recommendations from TA assignments as a check on technical quality. Twelve of the 15 respondents to the assessment's on-line survey credit WHO/GTB/TSC with doing a good job in identifying quality experts to provide TA to country NTPs.

WHO/GTB/TSC utilizes facilitative communication with TA stakeholders before and during TA activities as part of a broader coordination effort to improve TA provision. This communication regularly occurs with NTP staff and relevant personnel within the GF and other partners. Twelve of the 15 responses from the assessment's on-line survey confirm that communication of NTPs with WHO/GTB/TSC is open and easy. As a result, problems or issues identified during TA interventions can be addressed in a timely fashion, even while a TA activity is on-going.

The method of providing TA includes an internal evaluation of each TA event. WHO/GTB/TSC country focal points use a standardized WHO evaluation form that checks for the completion of the TA against the TOR. They also ask the country NTP staff to provide feedback on the quality, utility and value of the TA received. In addition to determining the effectiveness of the expert, information from the evaluations is used to both help determine progress in an individual country's TA plan and to improve the design of future TA interventions.

In practice, WHO/GTB/TSC maintains some flexibility in implementing TA plans for countries. The plans, developed for use over an entire implementation year, at times need to be modified to accommodate changes in country circumstances. Active coordination and regular communication with stakeholders allows WHO/GTB/TSC to quickly make changes in TA options in order to adapt to evolving country program needs. Designs for TA too can be updated or modified to meet changing country or stakeholder requirements.

The types or models of TA available for use by WHO/GTB/TSC for in-country support include:

- Short-term TA (STTA), from one to three weeks in duration.
- Medium-term TA (MTTA), from three weeks to three months in duration.
- LTTA, more than three months in-country.
- Ad-hoc TA or support (not originally part of a TA plan but arising to address an unforeseen need)

WHO/GTB/TSC country focal points reported that most commonly type of TA used, by far, is short-term. According to the 2018 Implementation Plan, of the 105 approved activities, 46 (44 percent) of the activities involved development of a key policy or guidance document, 12 (11 percent) were for joint missions or TA follow-up/supervision missions, nine (8 percent) training activities, and the remainder were for TA events, all of various lengths of duration up to four weeks.

Five of the 15 online respondents indicated that LTTA would be their preferred TA model, five others expressed a preference for medium-term TA or repeated STTA, and four indicated that STTA was sufficient. After reviewing the information gathered and considering how various TA activities are matched to country specific needs, the assessment team developed a comparison of types or models of TA and some of the different applications that seem most suited for them. In addition, the assessment team identified relative advantages and disadvantages of the various TA models (see Figure 2), taking into consideration the key challenges that the TSC faces with respect to planning TA, including a small pool of available qualified French-speaking consultants, country security issues, differing levels of NTP skill and competence, and relatively high turnover rates of key staff at NTPs in some countries. This review of these concludes that, by and large, the TA models have been appropriate although many informants noted the need for more continuity and follow-up of activities.

TA model	Most appropriate for...	Advantages	Disadvantages
Short Term TA	<ul style="list-style-type: none"> Remote or in-country; may be international, regional or in-country expert Document reviews (e.g., technical reports) Assistance with document production (e.g., grant documents, policy, guidelines, NSP) Participation in short events (trainings, workshops, etc.) Planning trips Monitoring visits 	<ul style="list-style-type: none"> Easy planning and budget management Number of potential consultants greater due to availability (preference for short term vs. long term assignments) Lower cost 	<ul style="list-style-type: none"> Delays in timeline (e.g., due to availability of TA provider) may postpone other planned activities May not promote deep understanding of country conditions More challenging to foster strong relationship with counterparts Without local support/follow-up, for long term activity, may be slow-downs between STTA visits; may need to “restart” activities if too much time has passed TA providers may have very different styles and approaches
Medium Term TA	<ul style="list-style-type: none"> In-country; may be international, regional or in-country expert Support for scale-up/roll-out of interventions. Providing capacity building, showing how to manage scale-up/roll-out of interventions. 	<ul style="list-style-type: none"> Allows for consultant to gain deeper understanding of country specific issues May promote bigger impact or more results over time (by catching unanticipated challenges early on) Monitoring is facilitated 	<ul style="list-style-type: none"> Less availability of qualified technical experts (especially French speakers) Adds to the cost of intervention (but may reduce the need for follow-up STTA)
Long Term TA	<ul style="list-style-type: none"> In-country; may be international, regional or in-country expert or generalist Capacity building of local counterparts – where NTP is very weak Secondments; filling a void, where WHO is weak Providing continuity for a complex string of TA activities 	<ul style="list-style-type: none"> Promotes consistent style and approach to TA Fosters strong relationships with counterparts Promotes deep understanding of country conditions Greater support for TA planning and M&E activities May promote faster achievement of results 	<ul style="list-style-type: none"> Low availability of qualified experts for LTTA (especially French speakers). Costly, especially for international consultants. Consultant may be pulled away by NTP to work on activities not in the SOW.

Figure 2. Modes of Technical Assistance

The designs for and models of TA utilized by WHO/GTB/TSC are producing results in country TB programs. For example, the grant’s annual report for 2017-2018 documented that the overall performance of TB grants in the USAID 30 priority countries exceeded results achieved for the non-TB components in GF grants for the same countries. Informants at the GF universally credited the TA provided by WHO/GTB/TSC with enabling countries to more effectively use GF resources.

When asked how these informants knew resource utilization was improving, they usually cited increases in draw-downs or expenditures under the GF grant or shifts in the country’s assigned GF grant grade (such as A1 or B2, etc.).

“In the country backstop, WHO’s technical assistance has been very effective; it helped increase the country’s absorptive capacity and effective utilization of Global Fund resources by nearly two-fold.” – *Global Fund portfolio manager*

Similarly, informants generally acknowledge that the TA is contributing positively to improvements in TB program performance. Such improvements, for example, include significant increases in the proportion of TB cases with access to GeneXpert (including rapid test for rifampicin resistance) at the time of diagnosis within countries receiving related TA. WHO/GTB/TSC delivered TA for GeneXpert

expansion and updating national diagnostic algorithms in: Angola (2017), Burkina Faso (2017), Cameroon (2017), Central African Republic (2018), Côte d'Ivoire (2017), Nepal (2017), Niger (2018), Senegal(2017) and Madagascar (2018).

However, the approaches used for following up on the recommendations from TA activities or for helping NTPs to implement TA recommendations seem limited. For example, within country WHO offices, local staff often are overstretched and usually, there is no one in the country office solely dedicated to supporting TB. In addition, according to WHO/GTB/TSC country focal points, the availability of needed technical resources at the regional offices is uneven between offices whose responsibility for monitoring the implementation of recommendations from TA activities or determining how well recommendations are put into action within a country program typically falls upon Geneva-based WHO/GTB/TSC staff (see response to Assessment Question 4).

Frequent communication, as well as strong coordination, are used by WHO/GTB/TSC to identify whether or when TA recommendations are implemented. When NTPs need help to implement recommendations, the TA options perceived by WHO/GTB/TSC to be fundable under the USAID grant are limited to short-term models. In interviews, WHO/GTB/TSC informants expressed the desire to use longer longer-term TA models as additional options to help build capacity within NTPs or to contribute to more rapid implementation of TA recommendations. However, when NTPs need help to implement recommendations, the TA options perceived by WHO/GTB/TSC to be fundable under the USAID grant are limited to shorter-term models. Nevertheless, WHO/GTB/TSC has successfully employed different approaches to STTA to address specific TA objectives and contextual challenges. For example, in Burkina Faso, an intensive, repetitive TA approach was used from 2016 to 2018 to address the complex limitations in the ability to expand GeneXpert testing due to infrastructure and human resources. A TA plan was developed that included multiple missions lasting one month each, complemented by continuous off-site support.

Objectively determining if TA is achieving “maximum results” is complicated due to the wide range of possible measurement techniques that would be required and the extensive variation in country circumstances. Additionally, most of the 12 indicators included in the USAID grant to WHO (and reported on) are higher-level measurements of GF functions or overall TB control progress and are not necessarily directly related to lower-level outcomes from TA plans for specific countries. The TA plans do not normally include descriptions of the overall programmatic improvement objectives or outcomes expected from the completion of the combined, envisioned TA. The plans also are not linked to a set of measurement indicators for the achievement of the desired specific outcomes or objectives from the TA delivered (see response to Assessment Question 4).

“WHO/TSC is an important part of the solution to problems facing country TB programs.” – *Global Fund portfolio manager*

CONCLUSIONS

From all the information gathered during the assessment, the team concludes that WHO/GTB/TSC’s TA activities and coordination efforts reflect the operating principles of the GF’s Partnership Strategy to achieve high country level impact. Feedback from country NTPs, the GF and other stakeholders provide an important means of assessing the impact of the TA provided to countries and contributions to the support of GF TB grant implementation. However, in the absence of an articulated framework for intermediate results (with a set of defined indicators related to the outcomes and objectives contained the USAID-grant’s scope of work), the full range of results is not completely documented.

The assessment team also concludes that the WHO/GTB/TSC's TA and coordination efforts effectively support the GF grant cycle in USAID's priority countries. The country profiles accurately identify country needs and the process used to develop TA plans successfully produces appropriately designed TA interventions to address these needs. Regular monitoring of country-specific TA plans does help to ensure the effective implementation of national TB strategic plan in the priority countries. In addition, WHO's work enables the effective use of GF resources in countries receiving the TA. The assessment's online survey also showed that NTPs perceive that WHO/GTB/TSC works well with the GF in responding to country needs and coordinates well with other TB partners in country.

In addition, the methods used by WHO/GTB/TSC to review and evaluate the quality of TA capture progress in the provision of TA and when there are needs for further assistance. The evaluation steps employed for TA activities allow for the identification of best practices and lessons learned in both the design and delivery of assistance. Experience gained from past provision of TA is applied to ongoing designs of assistance efforts, improving the general effectiveness of the delivered TA.

In general, the way WHO/GTB/TSC designs and delivers TA to the priority countries does contribute to the achievement of significant country results. WHO/GTB/TSC's annual report for 2018 noted that more progress is achieved in countries where TA plans take longer term views and include medium to longer-term TA. Such TA can be delivered by an expert at the WHO country office, the NTP or the principal recipient (PR) level. The 2018 report, as well as interviews with various informants, indicate that approaches to TA planning that combine country-based, medium to longer-term support with specialist short-term TA are most effective and have the most potential for achieving high impact. The inclusion of medium- to longer-term TA with STTA to achieve meaningful outcomes also contributes of greater capacity development within NTPs. The need to combine longer-term TA with short-term TA appears greater for weaker NTPs or where the contextual challenges are particularly complicated.

OPPORTUNITIES FOR IMPROVEMENT

When transitioning from the development of a country profile and defining a TA plan for the same country, the process for prioritizing the needs to be addressed could be based on more explicit criteria. These prioritization criteria could also be communicated to partners and used to guide complementary planning.

Although strong, the review of the country implementation planning documents shows that the TA planning process could do more in defining the expected relationships between planned TA activities and intended program outcomes or objectives. TA plans, for example, could include descriptions of the overall programmatic improvement objectives or outcomes expected from the completion of the TA envisioned in the plan. Whenever possible, expected outcomes from the TA also could be shown in the plan as contributing to the achievement of one or more of the five higher-level objectives described in the grant SOW. By linking the TA plans to a common set of measurement indicators for the achievement of the desired specific outcomes or intermediate program objectives expected from delivering the TA, the results of designed TA could be better captured, evaluated, and incorporated with the grant's regular reporting.

Although the assessment team concludes that the use of STTA has been largely appropriate, as countries transition from grant-making and policy and strategic planning to strategic plan implementation, it shares the view of the WHO/GTB/TSC, several NTPs, and GF portfolio managers that a wider range of operational formats or models for medium and longer term TA could improve the ability of WHO/GTB/TSC to follow up TA recommendations and better assist country programs with

implementing such recommendations. The dedication of more resources for follow-up missions, to monitor and assist with the implementation of TA recommendations, could improve both program impact and capacity-building within NTPs.

To support this approach to alternative TA model design, operational definitions could be developed to match the circumstances of countries. For example, the definition of medium-term could be one to three months or, for longer-term, three to six months or a series of one-month TA interventions not to exceed six months in a single year. Any selections for a wider range of operational definitions of TA formats or models should be developed in consultation with USAID. A common understanding of the standard TA formats that can be utilized under the grant could simplify the approval process for specific, planned TA activities.

ASSESSMENT QUESTION 2: HAVE THESE MODELS BEEN RESPONSIVE TO CLIENT NEEDS?

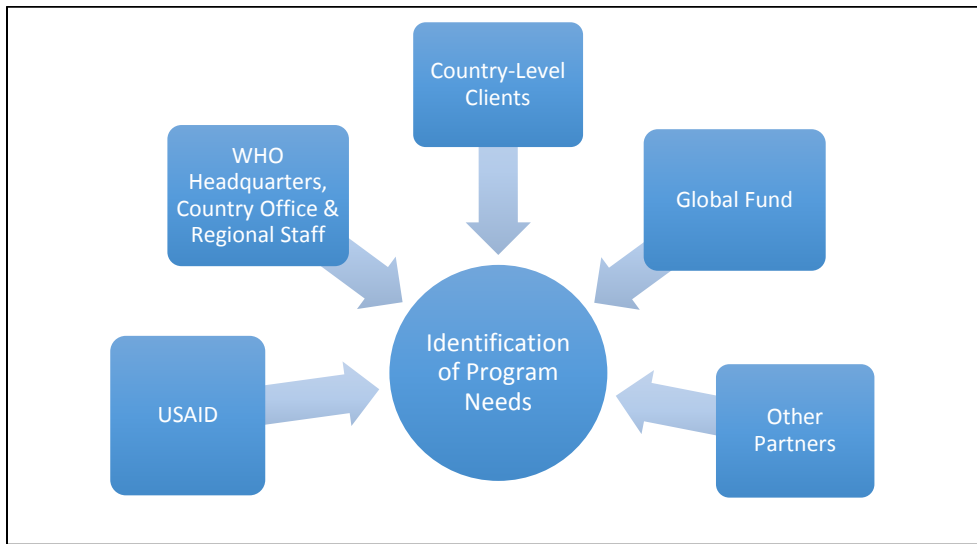
FINDINGS

With the objectives of the grant focused on assisting countries to successfully access and utilize GF resources for TB control, the relevant client entities involved, are obviously those with a stake in the GF processes for resource allocation to or utilization by country TB programs. The nature of client needs, therefore, is usually based on how the client is involved with or supports these country programs. WHO/GTB/TSC's efforts to address client needs also are oriented around country-specific implementation scenarios.

Among the clients whose needs WHO/GTB/TSC tries to address is USAID itself. WHO/GTB/TSC communicates regularly with USAID staff about how its efforts can meet USAID organizational needs. Input from USAID is used to strengthen efforts to support country TB programs. For example, the recommendations from USAID to systematize methods to define country program needs and to further organize the provision of TA activities led to the development of country profiles and TA plans as tools to improve overall implementation. These tools, adopted by WHO/GTB/TSC, are both currently in everyday use in the work of the grant. To meet the information needs of USAID, WHO/GTB/TSC has used weekly phone calls, and submits monthly and quarterly reports showing progress in relation to the TA plans, in addition to ad hoc communications as needed.

The protocols established and utilized by WHO/GTB/TSC to develop country profiles actively involve a full range of clients in the identification of TB program needs. By engaging stakeholders in this process (see Figure 3), clients have a voice in defining what needs should be addressed by WHO/GTB/TSC's efforts and the provision of TA. Although a range of clients are involved, the identification of program needs is largely a country-led process.

Figure 3. Inclusive Process for Identifying Program Needs



The collaborative processes used with all stakeholders for establishing and reviewing country-specific TA plans provide another venue for clients to communicate expectations surrounding the provision of TA. WHO/GTB/TSC’s coordination effort promotes transparency and the active involvement of key clients in the conceptualization of TA approaches.

WHO/GTB/TSC designs specific TA activities to respond to needs identified at the country level by country NTP managers, in-country WHO office staff, and others. Established procedures for involving clients in the TA-provision process (such as having NTP managers review and approve TOR for specific TA event) give clients opportunities to provide input on how to best meet their needs during implementation.

TA plans and activities also are coordinated with the GF and other stakeholders to improve responsiveness to these clients. WHO/GTB/TSC’s extensive coordination efforts include participation in GF country team meetings, participation in various Stop TB Partnership venues, meetings, and less-structured email communications and phone calls. These efforts provide numerous opportunities for the GF and other partner stakeholders to build good working relationships and to freely communicate their perspectives on whether planned or on-going TA work is responsive to their needs.

“The active engagement of the country in the identification of needs and planning of WHO technical assistance makes the TA more responsive to our program needs.” – *Country NTP manager*

After TA plans are prepared and TA activities are underway, WHO/GTB/TSC monitors and reviews the provision of TA to determine if there are additional needs at the country level or with other clients to support TB programs and their effective use of GF resources. Since WHO/GTB/TSC’s process for evaluating individual TA activities includes steps to obtain feedback from country-level (i.e., NTPs) and other clients, the standard TA evaluation protocol utilized by WHO/GTB/TSC serves as an ongoing check on responsiveness to client needs. This feedback allows WHO/GTB/TSC to modify or adjust the provision of TA during an implementation year, if required, to better respond to client needs.

Informants from the range of client organizations reported their needs generally are being met by the implementation efforts of WHO/GTB/TSC. Data collected through interviews and the online survey

confirm this opinion.⁴ Informants also noted that when issues did arise that required inputs from a variety of clients for resolution, these were successfully addressed in a timely manner through the regular communications channels or, if needed, through more formal mechanisms, such as the TB Situation Room.

The methods used by WHO/GTB/TSC for coordination were cited by informants as being particularly effective in enhancing responsiveness to clients. Informants at the GF and within TA partners greatly appreciate the benefits that the coordination efforts bring to making their needs understood and understanding how WHO/GTB/TSC implementation work is responding to expressed needs.

“[The WHO/GTB/TSC] is a very transparent program that has helped to bring people together and improve coordination.” – *Global Fund portfolio manager*

In our interviews, NTP managers consistently stated that TA from WHO/GTB/TSC has and is generally responding to their program needs. Responses from NTP managers to the online survey question, “Did the TA organized by WHO adequately address the targeted needs of your program?” also gave high scores (an average of 3.6 out of a possible 4) to the responsiveness of WHO/GTB/TSC’s TA to country program needs (Annex V).

“Changes occurred only when everyone was at the table together to discuss issues.” – *Technical partner*

For some countries, there remain unfulfilled needs for assistance in showing or demonstrating how to implement state-of-the-art TB control approaches within specific program contexts. Several informants reported challenges to fulfilling the needs of some country programs to quickly implement the recommendations from specific TA interventions or to put those recommendations into action within national TB programs. Such challenges have included: the lack of

“There is a need to go beyond telling us what to do; we need more assistance to help us do it.” – *Country NTP manager*

TB-dedicated staff at WHO country offices who can help TB programs make suggested improvements; limited availability of technical staff at WHO regional offices; limited options for providing longer-term TA in countries to help programs implement the recommendations; and delayed communications from country programs on the status of TA recommendations.

Some informants within client organizations (such as the GF or technical partners) also reported not always knowing when or if recommendations from TA events are implemented within a country program. Communication with clients on the follow-up of TA recommendations seems to vary between countries and, at times, be incomplete. The extent of follow-up performed appears to be somewhat dependent upon the person backstopping specific TA activities.

CONCLUSIONS

Overall, the TA provided through the grant to WHO/GTB/TSC has been very responsive to most client needs, with several informants noting that this responsiveness has even improved in recent months. Notably, WHO/GTB/TSC’s efforts have been particularly successful in responding to client

“WHO’s TA and coordination efforts responds to our needs very well. It makes a real difference.” – *Global Fund portfolio manager*

⁴ Of the 15 respondents to the online survey to NTP directors, nine reported that the TA they received completely addressed their TA needs, and six reported that the TA they received satisfied their TA needs somewhat.

needs related to the support of: effective implementation of GF financed activities at the country level, productive coordination of GF grant implementation at the global-level, and the preparation of country-specific new funding applications and TB national strategic plans for GF processes.

An important ingredient of WHO/GTB/TSC's success at meeting the needs of clients is the effectiveness of its coordination strategy. The high-quality coordination work creates avenues of easy communication with clients. Clients acquire a better understanding of country priorities and the purpose of specific TA activities and are able to express how well the TA meets their needs. The coordination work is critical to the grant's ability to meet the varied needs of such a wide range of clients. Therefore, the time and effort required to achieve this level of coordination is well placed.

The provision of opportunities for country-level clients (NTPs, WHO country and regional offices, etc.) to provide feedback on and evaluate TA activities strengthens WHO/GTB/TSC's ability to assess how well the needs of clients in-country are being met. With feedback being solicited from countries after the completion of each TA event, WHO/GTB/TSC can modify, if needed, how specific TA plans are implemented in order to better respond to country needs.

Among informants, there is a widely perceived need for more medium- to long-term TA options to better support country TB programs. In particular, longer-term TA models are needed to help country programs implement TA recommendations. Additional medium-term or longer-term TA models also are needed within WHO/GTB/TSC's regularly available implementation options to better support operationalization and implementation of strategic plans, especially in countries with weaker national TB programs.

OPPORTUNITIES FOR IMPROVEMENT

Being a product of a broad client review and a USAID approval, TA plans, once established, become a defined pathway for implementation. If circumstances in a country change or an unforeseen need quickly develops, a TA plan may need to be modified. Information gathered from informants included a suggestion to make TA plans more flexible or easier to obtain approvals to modify as a means of better responding to country needs.

Follow-up efforts, after the provision of TA and supporting country programs to put TA recommendations into action, could be strengthened to respond to country clients' needs in this area. For example, using longer-term TA options to help with implementing TA recommendations could improve responsiveness to some country program needs. Matching the most appropriate type of TA, and the strategic mix of TA models over time (see Figure 3 above), with the type of country need that existed or emerges after the initial provision of TA may strengthen responsiveness. For example, showing how to implement TA recommendations may require longer periods of assistance, especially in countries with weaker NTPs and countries where the Country WHO office has limited capacity to provide this type of support.

Additional opportunities could be created for other technical partners and the GF to review recommendations from specific TA events. One option to do so might be to modify the current TA tracking tool used by WHO/GTB/TSC to include a summary of the key recommendations when TA activities are completed. A wider review and sharing of TA recommendations may help in identifying a wider range of alternatives to support countries in implementing the recommendations.

A broader sharing of information on whether or not recommendations from TA visits have been implemented could improve awareness within stakeholder clients about progress within country

programs. This information also could help the client community gain a better understanding of the results being achieved by the TA efforts.

ASSESSMENT QUESTION 3: HAVE THESE TA MODELS BEEN EFFICIENT IN TERMS OF PROCESS?

To respond to this question, the assessment team conducted an analysis of WHO/GTB/TSC workflow and the processes involved in carrying out TA design and implementation activities. The information utilized for the analysis relied substantially upon document reviews and interviews with WHO/GTB/TSC staff and key informants representing stakeholder groups. The analysis focused on activities since January 2017, after the WHO/GTB/TSC shifted from providing TA on a more ad-hoc, country or GF request basis to a more strategic TA planning process; when relevant, and when information was available, references are made to changes that occurred over the implementation period.

FINDINGS

A detailed list of common steps or tasks WHO/GTB/TSC used in implementing USAID grant related TA activities, with corresponding estimates of the average time required to complete each, is presented in Annex VI. Since WHO/GTB/TSC has not systematically tracked the time required to complete tasks, this analysis is based on estimates of the time needed for tasks provided by staff when they were interviewed. The list of tasks applies to all TA models used by WHO/GTB/TSC. The timelines in the list expand or contract slightly depending on the number of activities to be approved, the capacity of the NTP and the availability of key staff at the WHO Country to support the NTP and the Regional Offices to support TA provision as well. The total time required to develop the country profile and the corresponding implementation plan is estimated by WHO/GTB/TSC staff to be approximately one month. The time required after submission of the country profile and implementation plan to USAID for approval and deploying the first TA activity can be three to four months.

There are few opportunities to streamline the workflow process. The time needed to complete WHO procedures, including the call for consultants and consultant contracting, and essential inputs from WHO regional offices on TA plans and implementation, are beyond the control of the WHO/GTB/TSC. Similarly, the time needed to obtain approvals from national authorities is also beyond the control of the WHO/GTB/TSC, with the challenge of ensuring continuity with in-country counterparts in several countries with a relatively high turnover of NTP staff. The time required to obtain approvals from USAID varies by country and the complexity of the implementation plan as well. Finally, obtaining clearance from USAID country missions, a relatively new requirement, can add up to a month to the timeline and is also beyond the control of WHO/GTB/TSC. Other factors can interrupt or add on to the timeline, such as unplanned and ad hoc requests for TA support or scheduling changes.

Collaborative initiatives and tasks requiring inputs from others are prone to being less efficient compared to unilateral or “top-down” approaches. However, efficiencies can sometimes be gained by employing strategic communication and management practices and tools. Over time, WHO/GTB/TSC identified performance challenges, such as delays in implementation due to communication breakdowns, and also identified some best practices to help mitigate against them, such as strategic carbon copy email practices and verbal follow-up of written communications. Indeed, the assessment team observed that WHO/GTB/TSC has a reputation among its stakeholders of having improved the way it works and is considered to be managing the grant efficiently.

Staff Management

There are currently 17 staff at WHO/GTB/TSC. Of these 17, 12 are professional staff, three are consultants, and two are general services staff. At the time of the assessment, seven staff are directly funded (two full-time and five part-time) by the USAID grant as portfolio managers. Since 2017, the USAID grant covers 60 percent level of effort of a financial officer who also serves other WHO/GTB teams. In addition, WHO/GTB/TSC has invited two technical staff from other WHO/GTB teams to serve as country focal points (although they are not directly supported by the USAID grant).

The staffing structure for implementing the USAID grant is relatively flat. WHO/GTB/TSC has designated a USAID grant manager, fully funded by the USAID grant, with the responsibility to facilitate the timely planning and implementation of all of the TA implementation plans. The grant manager also coordinates regular reporting to USAID, in association with other WHO/GTB/TSC staff working on the grant. An important function of this position is to triage USAID priorities and concerns with other staff, the GF, and other technical partners.

The approach for managing the grant is based on cross-functional, or matrixed, relationships between staff and between different WHO/GTB teams (see Figure 4 for illustrative matrix). Some grant country focal points also serve as technical backstops for the grants and have technical homes in other WHO/GTB units. Matrix approaches to project management are typically less expensive and more flexible than other approaches (such as those based on dedicated functional teams) because they facilitate the sharing of scarce resources, (highly specialized technical staff, for example) on a temporary or as needed basis.

In the case of the USAID grant, WHO/GTB/TSC country focal points all share the same country program management responsibilities for their assigned countries. Country backstops also have the ability to easily draw upon the diverse skill sets of their colleagues, from within WHO/GTB/TSC, other WHO/GTB teams and WHO regional offices, to match technical support needs with an appropriate technical expert. This matrix management approach also supports the WHO/GTB staff development objective by offering staff new challenges and opportunities for learning and relationship development, a strategy to strengthen the capacity of the overall team.

“The [WHO/GTB/TSC] is the most efficient WHO program I have ever worked with.” – *Global portfolio manager*

The WHO/GTB/TSC team has experienced some of the challenges associated with matrix management approaches. For example, while matrix management can offer relatively rapid access to specialized expertise, the approach can place a lot of stress on management, staff, and consultants with high demand expertise skills.⁵ Some WHO/GTB/TSC country focal points staff, for example, expressed that they have had to manage some difficult scheduling situations when there are several requests for the same TA from countries but only one or two consultants are available. Similarly, matrix management has also contributed to difficult situations for these staff and consultants when there were competing country needs or potentially conflicting technical priorities. WHO/GTB/TSC staff noted that when this kind of situation occurred it contributed to some scheduling conflicts, delays, and incomplete activities. This issue was also recognized by one interviewed NTP program manager who expressed frustration that a

⁵ Larson, Erik W. and David H. Gobeli. 1987. Matrix Management: Contradictions and Insights. California Management Review, Volume XXIX, No. 4.

https://www.researchgate.net/profile/Erik_Larson11/publication/265479828_Matrix_Management_Contradictions_and_Insights/inks/5b9715eb92851c78c4179d12/Matrix-Management-Contradictions-and-Insights.pdf

consultant supporting in-country activities was not able to provide a better level of support because the consultant was working in too many countries.

Figure 4. Illustrative Matrix Management Approach

Country\ Task	Develop Country Profile	Develop TA plan	Coordinate TA	Monitor TA	TA Lab Strengthening	TA MDR-TB	TA NSP	TA Childhood TB	Reporting
Country 1	●	●	●	●	○		●		●
Country 2	●	●	●	●	○	○		●	●
Country 3	○	○	○	○	○				○
Country 4	○	○	○	○		○	●		○
Country 5	○	○	○	○		○		●	○
Country 6	○	○	○	○		○		●	○
Country 7	○	○	○	○	○		●		○

Staff 1 ● Staff 2 ○ Staff 3 ● Staff 4 ○

WHO/GTB/TSC staff also expressed concern that matrix management approaches can make it difficult to gauge the workload of staff and there is the potential for individuals to be assigned to too many activities. To prevent these situations from becoming chronic issues that ultimately impact on performance, it is recommended that management should be alert to this threat and address it as soon as it becomes evident, a practice that seems to be implemented by WHO/GTB/TSC senior management. Fortunately, matrix structures tend to be very flexible and reorganization can be done with minimal disruption to the entire team. A recent case in WHO/GTB/TSC illustrates this flexibility. WHO/GTB/TSC hired a French-speaking consultant to serve as an additional country focal point to alleviate the work burden on the only other two French-speaking staff (13 of the 30 countries are francophone). This staffing modification, together with the redistribution of portfolios and the creation of the grant manager position, increased WHO/GTB/TSC's ability to support countries and created the new opportunities to focus on improving overall grant performance

Processes and Tools

In general, programs that use a matrix approach to management need to be supported by policies and procedures in order to avoid conflicts between team staff, and between different teams and offices. Examples include procedures for how to request a resource; prioritize projects, if they need the same resource; release a project team member; etc. Matrix management also benefits from such tools as document production guidelines and operations manuals. As a WHO entity, WHO/GTB/TSC is required to follow the organization's standard policies and procedures regarding communications with regional and country offices and to utilize tools such as standardized reporting formats, budget development templates or templates for developing TOR. Using these tools helps to ensure that approvals, contracts, and payments are forthcoming in a timely fashion and not delayed unnecessarily.

In addition to the tools listed above, the WHO/GTB/TSC team also relies on team-specific tools to support the consistent completion of the various complex tasks associated with TA design and implementation. The country profiles, corresponding country implementation plans, and associated TA tracking tools (such as the Implementation File), are examples of key management tools in use. Provided by the USAID TB team to WHO/GTB/TSC, the country profile template is a Word document and the implementation plans templates are in spreadsheets documents. These tools, available to all WHO/staff and USAID through the intranet SharePoint site, are developed and shared with all stakeholders (e.g., USAID, GF, NTP, WHO Regional and Country Offices, and technical partners) to support collaborative TA design and coordinated implementation.

While these management tools are valued, WHO/GTB/TSC and stakeholders acknowledge that they can be clumsy to use and dependent upon the timely inputs of country focal points to keep them updated. Indeed, spreadsheets are not intended to be used to manage data in the form of text (e.g., comments, notes) or to track information over time. Although the spreadsheet files are updated and archived, the limited text-editing features in spreadsheets can lead to text-related errors being relatively easily made and inadvertently replicated over time.

In addition, the assessment team observed that the spreadsheet configuration of TA implementation plans varied slightly between portfolios or countries. Such variation in standard formats is not an uncommon issue when there are many different users of the tool. The variations in configuration, however, makes it more difficult to pull together all of the various plans into a single document without significant manual modification. Databases are better suited for this type of data management, including for the production of standardized reports, although staff and stakeholders are more familiar with Word and Excel-based tools.

To help manage the administrative tasks associated with country portfolio management, WHO/GTB/TSC recently developed a checklist (Annex VII) as a job aid to ensure that all critical steps are followed in the planning and implementation of TA, that unnecessary delays resulting from missed steps may be avoided, and to facilitate the orientation of new staff to implement work under the USAID grant. The checklist details the roles and responsibilities of the country focal points, the technical focal points, and the laboratory focal point by task. Tasks covered in this checklist include the development and finalization of country profiles and TA plans, the development and approval of TOR, recruitment of experts, management of consultant contracts, filing documentation, grant management, and WHO/GTB/TSC travel. This new tool is considered to be a living document subject to further development and modification based on input from staff, and while staff are strongly encouraged to use it, they are not required to use it.

The WHO/GTB/TSC team acknowledges that very experienced staff have their own ways of working. While the team does not want to be “too bureaucratic,” increasing the formalization of the management process may help to reduce variation in the way tasks are carried out, reduce uncertainty in the status of country TA plans, encourage consistent follow-up and tracking of progress on TA plan implementation, and, avoid unnecessary delays due to interruptions in processes due to breakdowns in communications.

Grant Management Efficiency

Although WHO/GTB/TSC does not rely on Key Performance Indicators (KPIs), a standard project management method to monitor and assess aspects of efficiency (such as time management), it does report on high-level budget management indicators for regular reporting to USAID. These management indicators include monthly and quarterly budget pipelines status and average burn rate information. WHO/GTB/TSC understands how these indicators are used to assess progress on program implementation. At the time of this assessment, USAID informants reported that the burn rate has been sub-optimal. From the fourth quarter of 2017 to the third quarter of 2018, 25 of the 30 priority countries were focused on negotiating new GF grants. This process, according to GF-generated data, took an average of eight months to complete and informants report this impacted the implementation of TA. According to WHO/GTB/TSC’s 2018 Annual Report to USAID, the percentage of TA events completed according to TORs was 40 percent. An examination of the 2018 Implementation Plan shows that, as of September 2018, only 21 percent of activities were completed (Table I).

“The iterative process [in TA design] helps to transform a problem into a priority for action. Is it efficient? It’s a trade-off of time versus results” – WHO/GTB/TSC staff

“Up front planning and coordination help keep ad hoc activities at bay... It helps avoid duplication. It is like a red flag system.”
– Global Fund portfolio manager

Table I. Status of Approved Activities by Plan Year

Status	2017		2018	
	Number	%	Number	%
Planned	20	12.6%	68	64.8%
Cancelled	28	17.6%	2	1.9%
Completed	109	68.6%	22	21.0%
On-going	1	0.6%	8	7.6%
Postponed	1	0.6%	5	4.8%
TOTAL	159	100%	105	100%

Current implementation practices do address other, broader dimensions of efficiency under the USAID grant. Some of these may not be considered efficiency factors from a narrower grant management perspective. Key informants across all stakeholder groups agree that the frequent communications

undertaken by WHO/GTB/TSC country focal points (from TA design in particular to implementation) have successfully promoted complementarity and efficiencies across all stakeholders. Informants acknowledge and universally value how WHO/GTB/TSC’s communication and coordination efforts contribute to efficiencies in the interagency support of NTPs. According to one technical partner, this was particularly evident with the ability [of WHO/GTB/TSC] to convene key stakeholders.” Another partner concluded that “it is important that [WHO/GTB/TSC] take the leadership because there cannot be more than one captain of the ship.”

According to technical partners and GF portfolio managers, there have been few incidents of duplication of requests for assistance. In the past, these might have been identified only if the same technical partner was approached by both the NTP and the GF separately (e.g., Mali requested lab support from the

Union and GF). One technical partner reported that frequent communications with WHO/GTB/TSC helped to determine that an NTP director in a country where there were few qualified implementing partners available had requested the same assistance for lab support from each of them, perhaps hoping to receive support from at least one of them, and as a result a more optimal solution was found.

In another example, a GF portfolio manager for a country where there are many implementing partners reported that because the WHO/GTB/TSC country implementation plan was widely shared by the WHO country office in a proactive way, duplication of efforts was identified but subsequently avoided. In another country, the WHO country office was credited by the GF portfolio manager for flagging conflicting schedules for various capacity building activities. Indeed, the development and implementation of national strategic plans are consistent with this approach and one NTP director reported using the plan to support scheduling and keeping track of planned TA activities.

CONCLUSIONS

Overall, the process of TA provision has contributed to the achievement of the five objectives contained in the SOW of USAID's grant to WHO with some degree of efficiency. The assessment team concludes that important efforts have been made to achieve greater efficiencies in the implementation of the USAID grant. Examples of efficiency improvements include: reducing bottlenecks by addressing staffing challenges, standardizing and streamlining procedures where possible, and developing new management tools.

Management approaches succeeded in identifying programmatic gaps, redundancies, and duplication of efforts among technical or financial partners and addressed these issues through intensive and inclusive communication and information sharing strategies. While WHO/GTB/TSC faces challenges to the achievement of greater efficiencies, many of these challenges are largely beyond the direct control of the program. Such challenges include the dearth of qualified French speaking technical experts, the common pattern of high turnover of national NTP staff in countries, and the inconsistent availability and capacity of in-country and regional WHO staff to support TA planning and implementation. However, achieving even greater efficiencies may be at the expense of achieving high quality results currently produced through existing coordination and collaboration initiatives.

OPPORTUNITIES FOR IMPROVEMENT

Existing management tools can be further improved and used to identify more enhancements of efficiency. For example, WHO/GTB/TSC's new checklist tool and the implementation file can be modified to capture data to calculate the following standard efficiency indicators, or KPIs:

- **Average time spent:** The time needed to complete a certain task or activity at all levels of the grant implementation.
- **Completion rate and on-time completion rate:** Whether or not an assignment or task is completed and if completed by a given deadline.
- **Number of adjustments to the schedule:** The number of times adjustments are needed the implementation schedule.
- **Budget variance (and variance by line item):** The extent to which actual expenditures vary from the planned budget, from overall project to activity level if possible.
- **Number of budget iterations:** The number of budget versions produced before its final approval. A higher number of budget iterations means more time is being spent planning and finalizing a budget.

- **Number of errors:** How often things need to be redone during the project. This is the number of times you have to redo and rework something, which affects budget revisions and schedule revisions as well.
- **Client satisfaction:** The extent to which the client (e.g., NTP) feels that the TA objectives are met.

WHO/GTB/TSC may also consider creating new management tools to support the use of these KPIs to identify opportunities to further enhance efficiencies. One example—to improve consultant selection and scheduling—could be the creation of an “in-house” consultant roster that can be linked to any previous activities undertaken by the consultant (including reports and evaluations of completed TA assignments).

Given the complexity of country plans and the need for frequent updates and reporting requirements, the WHO/GTB/TSC should consider whether or not an investment in developing a database to help manage program information would be cost effective. As discussed above, although the Word and Excel tools are relatively familiar to all stakeholders, they are not optimal for project management purposes.

ASSESSMENT QUESTION 4: HAVE THE EFFECTS OF TB TA BEEN MEASURABLE, AND HAS THE PROCESS OF MONITORING TB TA PROVISION BEEN OPTIMAL?

The SOWs for the USAID grant specify the five objectives and seven expected outcomes from the grant. The SOWs also require annual reporting on a set of up to 12 indicators. The response to this assessment question is informed by a review of the SOWs, with a focus on the SOW for the 2017-2018 period, and reviews of the corresponding implementation plans and final annual reports. Opportunities for improvement also are identified.

FINDINGS

Measuring the effects of TA

The USAID grant’s SOW specifies five objectives and seven expected outcomes, with a slight variation over the years to reflect changes in GF policies or procedures and USAID TB priorities (see Annex VIII). Descriptions of the types of activities that contribute to the achievement of each objective also are provided in the SOW. The SOW also defines the 12 indicators that WHO/GTB/TSC is required to report on annually:

- Percent of GF TB grants with a rating of A1/A2, then compare to HIV and malaria. Report on 30 countries, and then on all 54.
- Percent of GF TB grants with rating of A1, A2, B1. Report on 30 countries, and then on all 54.
- Percent of GF TB grants with rating of B2/C (then compared with HIV and malaria). Report on 30 countries and then on all 54.
- Average number of months between GAC1 reviewing the concept note and GAC2 when the review should signal coming Board approval for countries receiving USG TA compared to countries no receiving USG TA (depends on funding cycle).
- Percent of funds released by the GF for the first tranche disbursement (by grants supported during grant-making with USG TA).

- Percent of grants where Concept Note was developed with USG TA support.
- Percent of completion of the Technical Support assignment (based on the TORs).
- Percent of priority countries that are utilizing the NSP tool to develop a high-quality budgeting TB NSP in countries where USG TA is providing support for the revision of NSPs.
- Number of rifampicin resistant/multi-drug resistant (RR/MDR) patients in countries receiving TA for MDR-TB that have started treatment in the previous 12 months.
- Percent of MDR-TB cases adhering to treatment after six months.
- Percent of countries reaching their MDR-TB grant targets.
- Amongst countries receiving TA for PMDT scale-up for programmatic management of drug resistant TB (PMDT), proportion that have updated guidelines to include shortened regimens.

Among the required indicators,⁶ four directly refer to or represent a specific potential measurement of a direct outcome of the provision of TA (see Table 2). Most (8) of the required indicators for annual reports measure various aspects of overall performance of country TB control programs for which some attribution to USG-supported TA through WHO/GTB/TSC could be made but not always measurable. As one partner said, “It is not clear if it is possible to measure impact... it is tricky to separate the contribution of TA to outcome. It may be more important to have process indicators.” Indeed, additional or intermediate indicators, directly linked to the five objectives or seven outcomes defined in the grant’s SOW, are not identified or commonly used in reporting on overall grant progress.

⁶ The indicators have changed slightly each year, reflecting changes in GF policy and/or changes in treatment recommendations and priorities, and reporting on indicators also changed in the course of the year in agreement with USAID. Targets are not provided.

Table 2. Grant Objectives and Corresponding Reporting Indicators showing direct outcomes related to TA

Indicator	2017	2018
Objective 2: Support the provision of comprehensive TA for countries that have applied for GF support in 2018 to ensure requests are – to the extent possible - aligned with TB national strategic plans.		
<ul style="list-style-type: none"> % grants where GF Funding Request was developed with USG TA support 	12 of 16 (75%)	23 of 30 (77%)
<ul style="list-style-type: none"> % countries that are utilizing the NSP tool to develop a high-quality budgeted TB NSP 	9 of 9 countries (100%)	13 of 13 countries (100%)
Objective 4: Facilitate PMDT scale-up including roll-out of shorter MDR-TB regimen and uptake of new drugs.		
<ul style="list-style-type: none"> Number of RR/MDR-TB or MDR-TB patients in countries receiving TA for MDR-TB that have started treatment in the previous 12 months 	15,294 RR/MDR-TB patients in the 30 countries	15,224 RR/MDR-TB patients in the 30 countries
<ul style="list-style-type: none"> Amongst countries receiving TA for PMDT scale-up, proportion that updated guidelines to include shortened regimens 	4 of 4 countries	25 of 25 countries

Informants agree that the TA provided is having a positive effect on country programs and their utilization of GF resources. The 2018 Annual Report to USAID presents high level effects for each corresponding technical intervention area (e.g., access to and absorption of GF resources for TB, strengthening laboratory and diagnostic network, and, scale-up of programmatic management of drug resistant TB) (see Box 2). These measures, generated with the support of WHO/GTB TB Monitoring and Evaluation (TME) unit, cover the period 2015 through 2017 only, with 2018 results not yet available. Effects of TA provided during 2018 are also presented, but primarily through a case study format.

Box 2. Selected Key Achievements of WHO/GTB/TSC Grant

Performance of GF TB grants supported by USAID improved: Performance of TB grants in the USAID 30 priority countries exceeds results achieved for malaria or HIV grants in the same countries.

Disbursements of GF TB grants: When comparing total disbursements made against the signed amount, TB disbursements (26%) are higher than the other components (22% or less).

Access to diagnostic tests increased: The proportion of TB cases with access to GeneXpert (including rapid test for rifampicin resistance) at the time of diagnosis doubled from the 77,343 in 2015 to 157,873 in 2017. The proportion of bacteriologically confirmed TB patients tested with GeneXpert doubled from 21% in 2015 to 43% in 2017, with a notable increase in the priority countries in the WHO African region (18 out of 30 countries).

Programmatic Management of Drug Resistant TB (PMDT) improved: Treatment coverage is slightly higher in the 30 USAID priority countries, when compared to the global average in (23% versus 21%) and 2017 (25% versus 24%).

- MDR/RR-TB treatment success rate progressively increased from 62% in 2010 to 70% in 2015 cohorts, exceeding the global average performance (50% in 2010 to 55% in the 2015 cohort).
- The number of patients on new drugs and reporting of adverse effects in patients treated with second line drugs increased by 36% from 3,345 in 2015 to 4,54366 in 2017.

WHO/GTB/TSC does not completely or systematically measure the full scope or effect of TA provided through the USAID grant. Many other “effects” of TA noted by NTP staff and others correspond to activity level outcomes usually defined in a measurement framework as intermediate results or outcomes, and would be accompanied by corresponding measurement indicators to support monitoring activities, and include a description of a causal pathway for attribution. However, WHO/GTB/TSC has not defined a specific results framework with an associated measurement protocol and established indicators. TA activities, therefore, have not been designed or implemented within the context of a formal measurement framework and implementation plans do not include any measurement indicators related to associated results. The absence of such a results framework, with common indicators to systematically measure the outcomes of TA efforts, hinders the ability WHO/GTB/TSC to systematically measure, monitor and confirm contributions of TA to key effects.

With guidance from USAID, WHO/GTB/TSC has been reorienting TA planning and implementation towards a more outcomes-oriented approach consistent with more strategic and longer-term planning. This change is reflected in the organization and content of the 2018 annual report to USAID which focused on outcomes from activities organized by priority technical area (i.e., strengthening the diagnostic network and quality management systems, PMDT, and facilitating implementation of NSPs). The style of the 2018 report contrasts with that used in previous years, which focused more on process or output level results. The 2018 annual report successfully captures measurable positive changes and represents a good model that should be replicated for reporting on progress in achieving objectives under the grant. Within the report, one finds measurement parameters for impact or progress towards country-program relevant progress that could be incorporated within a grant-specific results framework.

Measuring the effects of specific or collective TA activities is a difficult undertaking. Informants generally agree that there are many factors, besides whether TA events are completed successfully, that contribute to the ability, or lack thereof, within country programs to improve and make progress. Causality for positive change that is attributable to TA alone is difficult to establish. Established, common indicators for measuring the results of TA for TB, or other types of public health programs, are not in common use within the global health community. Nevertheless, some definition of measurement indicators is possible that can systematically capture incremental progress from TA provision over time.

Monitoring TA

WHO/GTB/TSC does not have a formal monitoring and evaluation (M&E) strategy or plan that describes how it tracks or monitors the outcomes of the TA activities, specifically under the USAID grant. Post-TA evaluations only document the completion of TA as per the TORs. As described in response to Assessment Question 3, some systems and tools are in place and roles and responsibilities with respect to monitoring TA implementation and the achievement of results are described, but various elements of a comprehensive monitoring system to track whether or not intended outcomes are achieved as planned are lacking.

“The level of TA training is not clear and it is not clear how the training will translate into concrete results.”
– *GF portfolio manager*

Focal points within WHO/GTB/TSC are responsible for the continuous review, documentation, and analysis of progress against planned program activities for which they have country or technical responsibility. These staff members focus on program inputs, activities, outputs, and not as much on intermediate or higher-level outcomes. While the TA is ongoing, the focal person maintains regular contact with the consultant to track progress and to identify and address any unforeseen challenges that would impact the ability to complete the TOR in a timely fashion. Following the TA, the focal point reviews the results and recommendations from the TA jointly with the NTP. If the technical area is best addressed by another WHO/GTB/TSC technical staff, then that person is asked to review the results and recommendations. Results and recommendations are also broadly shared with the GF and relevant technical partners.

“...thanks to the monitoring activity, [the problem] was caught. WHO facilitated a multi-partner meeting and helped with some small funds that had a big impact on the program performance.” – *NTP director*

Regular TA monitoring or follow-up visits are not included in TA plans. According to the 2018 Implementation File, TA for the 23 countries where TA was provided, follow-up or supervisory visits were planned for six countries (Central African Republic, Côte D'Ivoire, Guinea, Nepal, Niger, Senegal). These visits were tied to specific technical interventions. Joint missions with the GF, USAID, and/or technical partners that included TA monitoring were planned for another six countries (Angola, Burkina Faso, Ghana, Liberia, Pakistan, and Sierra Leone). These follow-up, supervisory or monitoring visits were to be conducted by WHO/GTB/TSC staff or WHO country or regional office staff, or by a technical partner or consultant.

The WHO country and regional offices have important roles in providing follow-up to activities and to communicate to WHO/GTB/TSC any implementation issues that may require additional support. As such, these staff perform a monitoring function and a TA progress measurement role. However, WHO/GTB/TSC, GF portfolio managers, and NTPs noted that in countries with a strong, consistent WHO in-country support (especially those with a dedicated TB point person), activities moved forward with less difficulty than in countries that do not receive this level of support. When asked if they could

identify how the TA they received had an effect, two NTP directors mentioned that more support for M&E was needed so that programs can monitor the progress made in their own programs.

At times, WHO/GTB/TSC country focal points have been able to take advantage of unprogrammed opportunities to monitor TA and receive feedback on the quality of that TA through their network of partners. For example, knowing that a technical partner was going to be “in the area,” one WHO/GTB/TSC country backstop asked the partner to “check in” on a TA activity and provide feedback (sometimes partners have volunteered the information). The sense of shared responsibility and mutual accountability created through collaborative planning of TA facilitates this type of exchange, and is especially helpful in countries where WHO has less capacity to provide that information.

Periodic joint missions represent important opportunities for WHO/GTB/TSC to review the implementation and quality of the TA. Joint missions, including Program Reviews, allow for all partners, technical and financial, to not only discuss technical objectives and priorities with country counterparts but also to identify technical challenges affecting implementation in one area that can affect implementation in another.

CONCLUSIONS

The effects of TA provision under the USAID grant are measurable, and progress towards achieving them also are measurable. TA plans and reporting are structured around key technical areas and describe the intended outcomes of technical activities. However, WHO/GTB/TSC could benefit from having a more formalized and outcome-oriented measurement framework to guide the design and implementation of TA for the purpose of tracking and communicating results.

Monitoring the provision of TA is good but could be improved. Monitoring activities should be programmed and supported by monitoring tools linked to expected outputs and outcomes. Reliance on WHO country staff to provide a high level of follow-up and feedback is not realistic for all countries, and reliance on ad hoc monitoring and feedback is not optimal. Therefore, where WHO country offices are constrained and the level of activity is high, an alternative solution should be identified, including programming for monitoring missions by the country focal point.

OPPORTUNITIES FOR IMPROVEMENT

By engaging in longer-term planning, WHO/GTB/TSC can aim at results that may take more than a year or two to achieve. Toward this end, WHO/GTB/TSC could develop a strategic results, or outcomes, framework to share with USAID.⁷ An important consideration, however, is that strategic objectives should not significantly change over the implementation period.

Much like WHO/GTB/TSC’s existing Implementation file, a well-developed framework can serve as a tool for multiple purposes, including planning, communications, and project management, as well as monitoring activities. A results framework could go beyond what is currently included in the Implementation File to specify the relationships between strategic objectives, intermediate results, and even sub-results of activities. In this way, a results framework could communicate the cause and effect linkages between a deliverable (e.g., described as a document or a functional lab) and intermediate results (e.g., a change in prescribing practices, or improved detection rates). As important, a results

⁷ <https://www.k4health.org/toolkits/measuring-success/frameworks>.

framework can be used to identify results areas and concerns that, while legitimate, would be outside or beyond the scope of work.

To strengthen the M&E component of the grant's management, WHO/GTB/TSC could include monitoring as a standard activity in their plans (a recommendation also suggested by WHO/GTB/TSC in the 2018 Annual Report to USAID). The TA plans should then specify who does the monitoring and when and how it would take place. In addition, WHO/GTB/TSC could critically assess the capacity of their in-country and regional colleagues to support different types and levels of support and adjust TA planning accordingly. Regular monitoring visits may be beneficial, especially where there is complex programming. When local NTP capacity is more significantly compromised, WHO/GTB/TSC may consider LTTA to support intensive TA monitoring.

V. OBSERVATIONS AND THOUGHTS FOR THE FUTURE

During the course of this assessment, the team had opportunities to obtain the perspectives of individuals from those involved with the implementation of the grant's work and those who benefit from the success of its efforts. We gathered information on how TA for country TB programs is identified, designed, delivered, and evaluated. We also asked a range of clients about how well their needs have been or are being met by WHO's implementation efforts under the grant and learned about some of the complications country programs face. In assembling and analyzing the information gathered, we made some general observations about the overall work of the grant and WHO/GTB/TSC in support of TB control programs.

THE VITAL ROLE OF COORDINATION

A key factor and a major contributor to the quality of all aspects of the grant's work, as well as its ability to achieve intended objectives, is coordination among or between stakeholders. Virtually all informants cited coordination as a necessary ingredient of successful implementation and praised the high quality of WHO/GTB/TSC's coordination effort. Indeed, the assessment team found that coordination plays a critical part in the identification of country program needs; the design and provision of TA; making the TA effective; identifying and responding to client needs; interfacing productively with the donor (USAID); and achieving greater efficiencies for the collective, cross-organizational support of TB programs.

"Changes occurred only when everyone was at the table to discuss things.... there should be joint missions that cover all points, not just one aspect." – Technical partner

"The joint mission with WHO, Milan SRL, and other in-country partners, organized by the GF, was very successful – we learned a lot." – GF portfolio manager

Quality, effective coordination, however, requires considerable time and effort. Given the total number of staff (five part-time and two full-time) funded by the grant, the range of stakeholders and the number of countries involved (30), WHO/GTB/TSC is achieving high-quality coordination with efficiency and effectiveness. The current reporting does not appear to fully reflect coordination efforts and, at times, only indirectly captures its productivity. Similarly, the workload needs and time demands required to achieve this high-quality coordination are being met consistently by WHO/GTB/TSC's staff. The level of coordination achieved, along with the resulting benefits to the support of TB programs, is worthy of recognition and acknowledgement.

INSTITUTIONAL FACTORS

WHO, as an international organization, brings a special set of characteristics to the work of the grant. In its role as the custodian of global health standards, WHO is the world authority on the technical dimensions of these standards. Program-specific technical recommendations, coming from or endorsed by WHO, carry an authority that is unmatched by others.

As the source of international, TB-specific standards and protocols, such as for MDR-TB, WHO is well positioned to provide TA to country TB programs. Some practices used by WHO/GTB/TSC in delivering TA to countries build upon this organizational advantage. For example, with WHO/GTB's internal technical review, TA recommendations come to country TB programs with an immediate assurance of being compliant with current WHO standards.

In addition, WHO has offices in most developing countries and maintains regular communications with ministries of health. The country presence, (supported administratively and technically by the WHO regional offices), along with its role in monitoring the overall status of health in countries, gives WHO a recognized voice at the country level concerning how well progress is made in disease control. This larger WHO role provides opportunities for programmatic follow-up to TA plans beyond the context of the TA activities themselves.

For the reasons listed above, in addition to being physically located in Geneva and in close proximity to the GF, WHO has been a good choice as a partner to help support country TB programs to access and utilize GF resources. In many ways, WHO/GTB/TSC is uniquely positioned to play a role in providing relevant TA for TB programs. Its organizational advantages improve the effectiveness and impact of WHO/GTB/TSC's TA efforts.

However, WHO is not an organization that implements health programs. The organization's capacity is limited in this regard and therefore, it must rely on external consultants to provide TA in best ways to implement TA recommendations. Similarly, the organization's orientation has not been specifically in program implementation or project management (including common tools like result frameworks or sets of intermediate result indicators). WHO/GTB/TSC has had to create new systems to use internally to strengthen how it implements the grant and improves potential for having TA efforts positively impact country TB programs.

WHO's bureaucracy and structure, with defined headquarters, regional office and country office roles, can complicate how a TA-provision effort located in Geneva responds to individual TB programs in countries. WHO/GTB/TSC uses implementation techniques that adhere to the assigned authorities of regional and country offices but also allow direct management functions for TA activities for countries.

The fact that WHO is an apolitical organization can be an advantage. It has the ability to maintain a long-term presence in countries even with the possibility of significant regime changes. WHO's presence in countries where USAID does not have direct assistance for TB is an implementation advantage for the grant. The organization's apolitical posture may also make advocating for greater political support more difficult in countries where TB programs suffer from a lack of political will.

ACTIVE COLLABORATION WITH USAID

Although WHO/GTB/TSC's TA activities are funded by a grant and, by definition, "owns" the TA program, it actively collaborates with USAID in the conduct of TA activities. WHO/GTB/TSC solicits input on TA plans from relevant USAID staff and regularly incorporates feedback from USAID in its TA implementation. The frequent and proactive interaction with USAID creates open and responsive channels of communication that help make implementation under the grant more likely to contribute significantly to USAID's larger goals for TB control in USAID priority countries. WHO/GTB/TSC's proactive collaboration demonstrates its continuing commitment to making the work of the grant productive for USAID's needs.

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