

Interim External Review and Evaluation of The Special Programme for Research and Training in Tropical Diseases (TDR)

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Acronyms

ADG	Assistant Director General (WHO)
APHSR	Alliance for Health Policy and System Research
ANDI	African Network for Drugs and Diagnostics Innovation
APOC	African Programme for Onchocerciasis Control
BL	Business Line
BMGF	The Bill & Melinda Gates Foundation
CIAM	Public Health Research and Development Centre, Gambia
CoE	Centre of Excellence
COHRED	Council on Health Research for Development
CPD	Continuing Professional Development
DEC	Disease Endemic Country
DF	Designated funding
DFID	Department for International Development (UK)
DNDi	Drugs for Neglected Diseases Initiative
EPPE	Effective project planning and evaluation
EU	European Union
EXG	External Relations and Governing Bodies (WHO)
FIND	Foundation for Innovative New Diagnostics
GCLP	Good Clinical Laboratory Practices
GCP	Good clinical practice
GLP	Good Laboratory Practice
GMP	Global Malaria Programme
GPELFF	Global Partnership for the Elimination of Lymphatic Filariasis
GSM	Global Management System
GSPoA	Global Strategy and Plan of Action
HAT	Human African Trypanosomiasis
HIC	High Income country
HIV	Human Immunodeficiency Virus
HMM	Home based management of malaria
HRP	Special Programme of Research, Development and Research Training in Human Reproduction
IDP	Infectious Diseases of Poverty
IPSAS	International Public Sector Accounting Standards
ISHReCA	Initiative to Strengthen Health Research Capacity in Africa
JCB	Joint Co-ordinating Board
LDC	Least developed countries
LF	Lymphatic Filariasis
LIC	Low Income country
LSHTM	London School of Hygiene & Tropical Medicine, UK

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MDG	Millennium Development Goals
MIC	Middle Income country
MMV	Medicines for Malaria Venture
MoU	Memorandum of Understanding
M and E	Monitoring and Evaluation
MVI	Malaria Vaccine Initiative
NTD	Neglected Tropical Diseases
OCPC	Onchocerciasis Control Programme
PDP	Product Development Partnerships
PI	Principal Investigator
PPM	Portfolio and Programme Management
PPP	Public–Private Partnerships
QA	Quality Assurance
QPBR	Quality practice for basic research
RCS	Research Capability Strengthening
R&D	Research and Development
RMS	Research Management Support
SAC	Strategic and Scientific Advisory Committee
SMG	Senior Management Group
SOP	Standard Operating Procedure
STAC	Scientific and Technical Advisory Committee
TB	Tuberculosis
TDR	Special Programme for Research and Training in Tropical Diseases
UD	Undesignated funding
UNDP	United Nations Development Programme
UNECA	United Nations Economic Commission for Africa
UNICEF	United Nations Children’s Fund
VES	Vectors, Environment and Society
VFM	Value for money
VOIP	Voice over internet protocol
WB	World Bank
WHA	World Health Assembly
WHO	World Health Organisation
^{WHO} /AFRO	World Health Organisation Regional Office for Africa
^{WHO} /EMRO	World Health Organisation/Regional Office for the Eastern Mediterranean
^{WHO} /SEARO	World Health Organisation Regional Office for South East Asia
^{WHO} /WPRO	World Health Organisation Regional Office for Western Pacific
WIP	Work in progress

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1. Executive Summary of Observations and Recommendations

There is general agreement that TDR is at a crossroads. TDR has had a worldwide reputation for innovation and excellence over a period of thirty five years. It has been responsible for supporting and training a high proportion of the scientists in disease endemic countries working on neglected tropical diseases and has had major involvement in treatment and prevention. Over the last years, encouraged by its past ability to mobilise resources and guided by the last major review, TDR embarked on an aspirational programme, expanded its staffing and moved into areas beyond its traditional activity focus.

With an overambitious budget, inadequate financial processes and unforeseen currency fluctuations, the special programme has found itself in financial difficulties and has no choice but to reduce staffing and refocus and rationalise its activities.

Many people see this refocusing process as a positive development having felt that TDR had “lost its way”. However, refocusing has resulted in some work being phased out, other activities being postponed and relationships with some partners being damaged. It has also resulted in some good staff losing their jobs and a mismatch between the competences of some remaining staff and the remaining activities.

“TDR is programme with a wonderful history and much loyalty from the research community and funders of research but recently it has lost its way and we have lost some confidence” DEC researcher

1.1 Research Focus

An overwhelming number of stakeholders interviewed believe that TDR should concentrate on its traditional area of expertise in neglected tropical diseases. However, they believe that it should stop activity related to HIV/AIDS, TB, health systems and possibly also work in malaria where it does not have comparative advantage and which are well resourced by other bodies. A focus on NTDs is still highly relevant with an estimated 1.4 billion people, one sixth of the world's population, being infected with one or more NTDs and another two billion people at risk. Whilst there have been major developments in some diseases which bring the possibility of eradication (e.g. lymphatic filariasis), there are others where significantly more research is required both for product development and for implementation

There is further a strong case that TDR does not have comparative advantage in product development research and should focus much more on implementation and operational research at country level. Working with private sector pharmaceutical companies is recognised as requiring a different skill set and the investment of significant resources.

There have been some issues concerning the quality of work led/ supported by TDR. This is recognised and actions have been taken but there is a risk of reputational damage. TDR needs to agree standards which are to be achieved across the organisation and these need to be monitored.

1.2 Stewardship

Thanks to its co-sponsors and hosting by WHO, TDR has significant convening power. This is also the result of thirty years work developing scientists who today are at the forefront of their profession. There is a recognised need for a body which is able to be seen as an independent and neutral party. It should also be able to convene scientists to review research findings and reach consensus, map both the need for research and potential funding sources and identify research gaps and facilitate these gaps being filled.

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This Stewardship function has significant value but it is only possible if TDR is truly neutral and is not a seeker of funding in competition with the experts it draws on. This potential conflict of interest requires consideration and the costs associated with stewardship require a further critical value for money study and consideration if a similar function could be undertaken in a different way at lower cost. The current methodology is almost certainly not sustainable nor cost effective although there is an ongoing need to provide a forum for mapping current initiatives, identifying gaps and advocating for these to be addressed. The products of individual focus groups have considerable relevance but only if they are produced quickly and disseminated appropriately

1.3 Empowerment

TDR has great credibility and comparative advantage in capacity building and institutional strengthening. This remains an area of huge relevance in the continuing efforts to control and eradicate NTDs. The effectiveness of TDR in this respect can be demonstrated by the large number of scientists in the field who have been supported in the past. It is not possible to quantify either numbers or career trajectories but there is strong anecdotal evidence.

The refocusing on institutions rather than just individuals is sensible but should not reduce investment in certain aspects of support to individuals particularly re-entry grants. TDR should continue to have major input to capacity building of individuals and institutions both through development activities and “learning through doing” It would be desirable for TDR to convene interested parties to agree both a competence framework for individuals and an organisational standard document for institutions

1.4 Governance

TDR is an organisation which has been undermanaged and has, as a result, experienced serious financial problems. It is evident that the current governance structure does not provide clarity about management decision making, responsibilities or accountability. There are no effective checks and balances. In order to move forward, TDR will need to review its governance structure so that it is fit for purpose. It is suggested that the current governance of TDR and its structure is revisited with a view to:

- Relocation of TDR in the same WHO cluster as Neglected Tropical Diseases (NTD) and malaria
- Establishing a “cabinet”, possibly reforming the existing Standing Committee, with a clear remit for strategic decision making, operational planning, holding the Director and senior team to account, monitoring of agreed activities, financial performance and adherence to quality standards.
- Revising the frequency of meetings (actual and virtual)
- Revising the remit of the current Joint co-ordinating Board so that a Stakeholder Forum is created with a role in advocacy, resource mobilisation, strategic consultation and information exchange
- Revising membership of the Scientific Technical Advisory Committee (STAC) to mirror the refocused areas of activity.

It is not clear how a new governance structure might be agreed and if it requires a revision of the MOU. Legal advice may be necessary to obtain clarity on a process for revision of the governance arrangements and it would probably need agreement from the co-sponsors and current JCB.

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1.5 Management

The structure of TDR will need revision if the research focus is narrowed but, in general, the new Senior Management Team arrangements appear to be working well. There is an urgent need, however, to strengthen the finance function by appointing a qualified accountant.

Internal management systems need considerable strengthening. Costing and budgeting had been unrealistic and there had been inadequate financial management information to exercise control. Although there have been moves to introduce risk assessment, this needs to be extended to risk management (i.e. mitigation of risk). Risks need to be assessed, evaluated for mitigation and high risks should be referred to the Cabinet. The performance management systems are not applied consistently and personal objective setting (linked to organisational goals) and appraisal is not driving activity. This needs reinforcement

TDR will need to refocus its activity, establish strong managerial systems, give partners and donors confidence and achieve financial stability and balance. This will need a Director with outstanding leadership powers together with management skills and the ability to communicate a compelling vision both internally and externally. There is no doubt that TDR continues to have the potential to contribute in a field which is still of huge relevance globally and to build on its past successes.

2. Evaluation Methodology

The terms of reference for the review are appended at Annex 1. The review has been undertaken by a team of consultants with backgrounds in science and health, governance, capacity building, monitoring and evaluation and economics. The scientist on the team conducted many of the interviews with TDR researchers but was not involved in writing the final report. In addition, the team has been supported by three senior scientists working on the field of diseases of poverty (Professor Phyllis Freeman, Professor Dan Colley and Professor Mary Ann Lansang) who provided input to the review topics, the interview questions, proposed interviewees and the final report format and content.

The team had limited time to undertake the exercise which consisted of a review of relevant documentation (see annex 2) together with both face to face and phone interviews with key stakeholders.(annex 3) Due to the time constraints it was not possible to interview all of the stakeholders identified but a process of triangulation was undertaken in order to substantiate facts as far as possible and to collate opinion in a way which reflected the overall comments collected. In a number of cases, follow up phone calls were conducted for further verification. Due to recent issues relating to budgeting and expenditure, the team agreed to look at planning and financial systems in greater detail. It was recognised that this was important to provide a level of assurance for current and potential funders. (See Section 5)

Whilst drawing from TDR's work in the past, the main focus of the review was the period 2008-11.

3. Background to the 2011 Review

3.1 Brief early history

TDR was established in 1974 as the result of a call from the World Health Assembly (WHA) which set the direction of the new body which would be a global UN sponsored entity to address diseases that were felt to be neglected through research and training, particularly in endemic countries. The Special Programme for Research and Training in Tropical Diseases was subsequently launched in November 1974. The co-operating partners (at that time WHO, UNDP and the World Bank) endorsed a Memorandum of Understanding in 1978 which established the governance structure of the Standing Committee, Joint Co-ordinating Group and Strategic Technical Advice Committee (in 1979). From the beginning, there was a strong emphasis on the involvement of disease endemic countries and participation by both funders and recipients.

3.2 2005-2006 Review

In 2005 the review recognised a major change in the research environment which had the potential to impact on TDR and its contribution. Changes included:-

- Epidemiological changes which caused TDR to reconsider its former focus on ten diseases
- A rapid growth in both resources and bodies involved in research with resultant fragmentation and potential duplication.
- Better alignment of funding with prioritised needs in disease Endemic Countries (DECs) and greater commitment to working in a harmonised way in line with the Paris Declaration on aid effectiveness. The need was recognised for greater co-ordination
- A recognition that DECs, despite support from TDR, required ongoing and strengthened capacity building particularly at strategic level in support of priority setting and research planning. In addition, there was a need to enhance innovation and product development in DECs, to build capacity for policy and implementation, to enhance research capacity in control programmes and strengthen national commitment to health research.
- Recognition of the need for research activities on the interfaces between research domains.

To respond to this changed environment TDR reviewed the mission, vision and strategic direction of the organisation in the business plan developed in 2008.

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3.3 Business Plan 2008

3.3.1 Mission

The current mission statement of TDR as outlined in the 2008 business Plan is in two parts

- Research and development into new and improved approaches on diseases of poverty.
- Empowering and building research capacity in the countries where the diseases are prevalent.

3.3.2 Vision

As detailed in the Business Plan 2008-13, the renewed vision of TDR is

- 'An effective global research effort on infectious diseases of poverty, in which disease endemic countries play a pivotal role.'

3.3.3 Strategic Direction

The 2008-13 business Plan identifies the following strategies for a collaborative framework to provide information to research players, to empower scientists from DEC countries as research leaders and support research in neglected priority areas:

- **Stewardship** for research on infectious diseases of poor populations: a major new role for TDR as facilitator and knowledge manager to support needs assessment, priority setting, progress analysis and advocacy, and to provide a neutral platform for partners to discuss and harmonise their activities.
- **Empowerment** of researchers and public health professionals from disease endemic countries (DECs), to provide support for training and research, and to build leadership at individual, institutional and national levels.
- **Research on neglected priority needs** that are not adequately addressed by other partners. This focuses on two research functions:
 - Research for innovation, including diagnostics and drug development, in which TDR would engage strongly in the GSPoA process.
 - Research for access and implementation coherent, with the increasing interest in health systems and operational research.

3.4 Structural and Procedural Changes resulting from the 2005-2006 review

Following the review, TDR restructured to support a number of time-limited business lines which were intended to improve end product focus and accountability. The aim was to become more "business like" with clear objectives and systems for monitoring. Four functional areas reported to Director's Office: Stewardship, Empowerment, and Research on Neglected Priority Needs and a small Portfolio and Policy Development team. Nine research business lines with a disease or function focus reporting to Research Coordination were identified with input from technical working groups, WHO departments, other stakeholders and an assessment of opportunities based on the current portfolio of work. Business lines relating to stewardship and empowerment were intended to be continuous but other business lines would be reviewed annually and change over time.

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3.4.1 Business Lines

The following business lines were established.

- BL1 Stewardship
- BL2 Empowerment
- BL3: Lead discovery for drugs
- BL4: Innovation for product development in DECs
- BL5: Innovative vector control interventions
- BL6: Helminth / NTD drug development and evaluation
- BL7: Accessible quality assured diagnostics
- BL8: Evidence for treatment policy of HIV and TB co-infection
- BL9: Evidence for antimalarial policy and access
- BL10: Visceral leishmaniasis elimination
- BL11: Integrated community-based interventions

These were to be reviewed for continuing relevance every year by the STAC.

The business plan endorsed by the JCB in 2007, identified an increase in resource mobilisation from \$50m in 2007 to \$80m in 2013 was required to fund the new strategy. Headcount was planned to increase by 6% p.a. from 85 up to the year 2013 to enable implementation of the business line workplans.

3.4.2 Innovation fund

An innovation fund of US 1m was intended to be established in the Business Plan to attract and promote new and novel research activities. These activities might, once piloted be scaled up either as part of TDR or in an external programme however this was not initiated

3.4.3 A widened research focus

Whilst continuing its commitment to fundamental research, TDR committed to an increased focus on impact driven research and an increasing “downstream” focus.

3.4.4 Mainstreaming gender

TDR committed to mainstream gender in all its stewardship, empowerment and research activities with a particular emphasis on evaluation and implementation research. Each business line would be required to report on its plans and progress to STAC.

3.4.5 Ensuring DECS play pivotal role

This would be achieved through membership on all key committees and working groups and by having research in DECS undertaken under a national PI. All research in DECS would strive to harmonise with national priorities and be undertaken through national programmes particularly for intervention and implementation research

3.4.6 Ensuring synergies across strategic functions and business lines.

There was recognition of the need for internal coherence within the programme and across WHO. This would be achieved by recognising the overlap of objectives, particularly those involving stewardship and empowerment. The importance of internal and external communication was stressed.

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3.4.7 Establishing a monitoring framework

The 2008-13 business plan envisaged a review would be undertaken in 2012 based on evaluating overall long term impact on the three strategic functions. It would measure progress on

1. Stewardship. Progress towards harmonisation of global research efforts
2. Empowerment. Progress towards DEC leadership in health research
3. Research on neglected priority needs. Progress towards enhanced access to superior interventions

Note: The JCB endorsed the decision that the review be brought forward from 2012 to 2011 due to the financial difficulties and the desire to have an oversight before implementing rationalisation and changes.

4. Recent History

4.1 Events in 2010 onwards and resultant changes

Although TDR achieved unprecedented levels of resource mobilisation in 2008/09 (\$77m) and 2010/11 (\$80m), these fell short of projected levels of funding required by the 2008-2013 business plan. Approved budgets for the two biennia had initially been set at \$121m and were later reduced to \$100m, which is still higher than historic budget levels and achieved income levels. In addition, pressure to implement the strategy and achieve a high financial implementation rate led to a recruitment drive before income levels had been secured. High fixed overhead costs (personnel and programme costs) relative to income levels were further exacerbated by exchange rate movements (an appreciation of the Swiss franc relative to the dollar). Finally, most of the increase in funding achieved in 2010 was designated funding which limited its use for fixed personnel and programme costs.

The budget approved for 2010-11 was openly aspirational but was supported by the STAC and SC and agreed by the JCB. However, it is evident from contemporaneous documentation and from interviews, that some individuals on these committees suggested that it was over ambitious and it does not appear that any formal risk assessment was undertaken. It followed on a period where funding for TDR had enjoyed an upward trajectory and assumptions were made that this would continue.

In the event, it became evident in early 2011 that the budget and plan were unsustainable due to a significant increase in staff recruited and adverse currency exchange rate. At this stage a package of measures were agreed by the Senior Management Group and the SC and communicated to the JCB including reducing staffing levels and cutting some planned activities. The JCB agreed a revised plan with a budget of \$95m. The consequences of the rationalisation included:

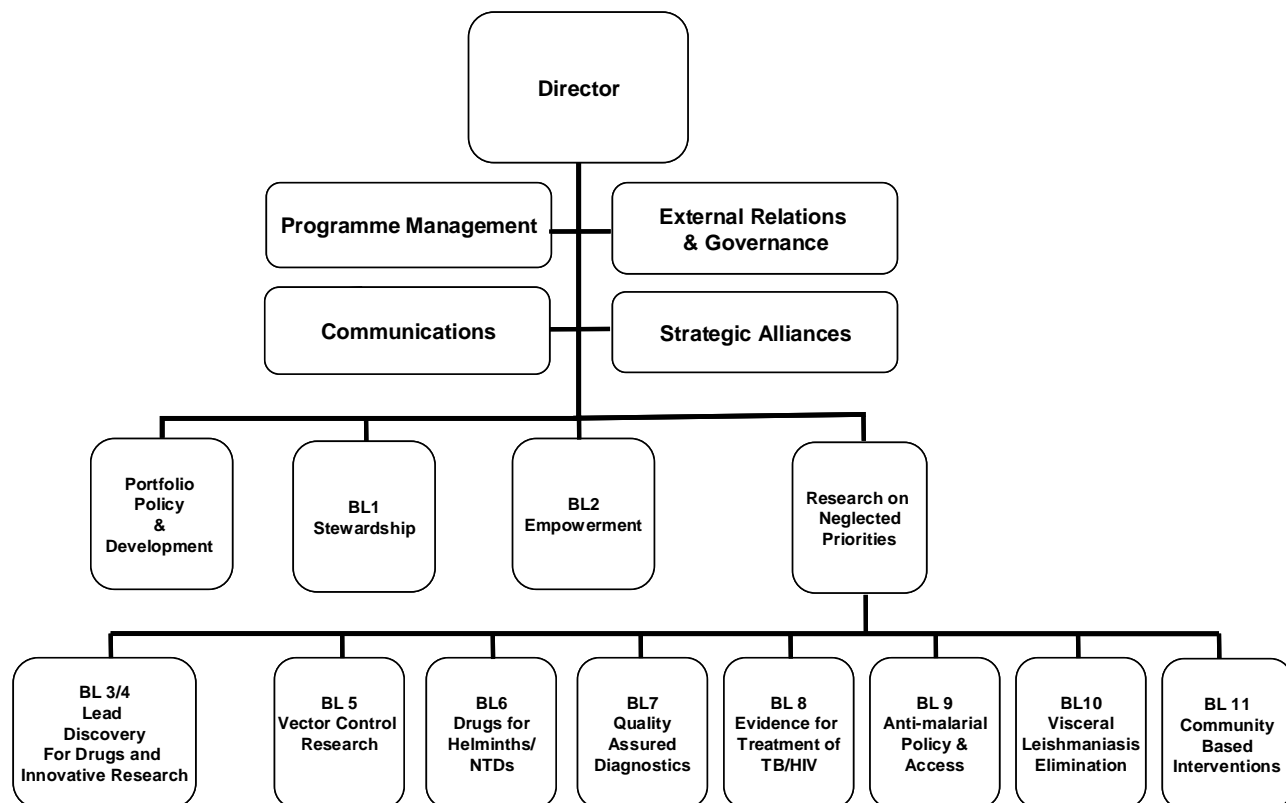
- Disbanding the business line structure
- Merger of stewardship and empowerment into one unit to cover : Priorities and Knowledge management (Stewardship), Leadership Development (Empowerment) and Innovation Networks
- Merger of visceral leishmaniasis activities with NTDs business lines into a single unit
- Mainstreaming diagnostic research activities across the various teams and closing the corresponding business line
- Creation of a new unit; Vectors, Environment and Society, by joining vector research and integrated community-based interventions by merging BL 5 and BL11
- TB/HIV integrated in a single unit with health systems
- Closure of the Strategic and Technical Advisory committees which were associated with each one of the business lines
- Phasing out of direct funding to lead discovery activities
- Delaying the launch of the Global Report (also delayed by the process taking longer than planned)
- Transitioning TropIKA to external partners

In addition, there was a restructuring of support units. In order to integrate technical and financial aspects of managing the programme, the Programme Management and Portfolio, Policy and Development units were merged into a single unit. The Strategic Alliances unit was terminated.

Staff numbers were reduced in all areas, resulting in a reduction in headcount from 96 at the start of 2011 to 64 currently.

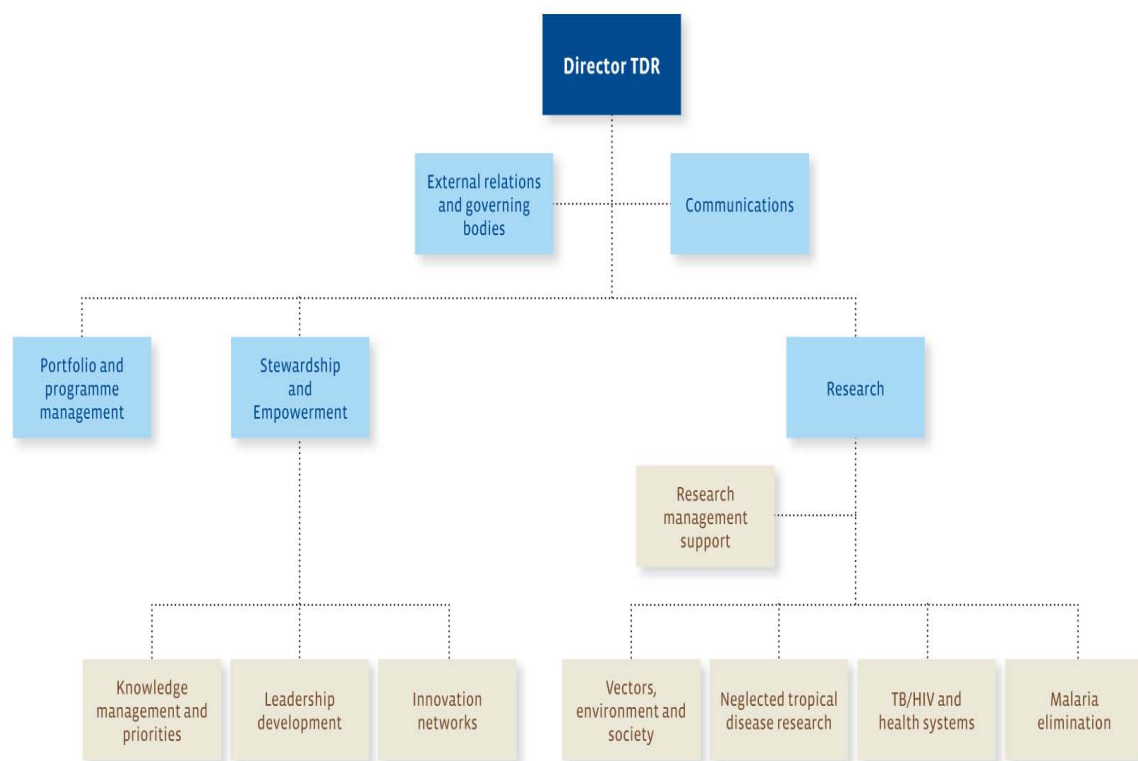
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Figure 1a TDR Organigram before May 2011 Restructuring



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Figure 1b TDR Organigram from May 2011



4.2 Summary of current financial situation

Failures in budgeting processes and financial controls, combined with pressure to rapidly implement activities set out in the 2008-13 business plan and detrimental exchange rate movements, have led to a significant expansion of fixed and activity costs ahead of income levels. Total costs, including liabilities for 2010/11, are estimated at \$98.0m relative to income levels of \$88.8m (including \$8.8m carry forward) (Table 1 & Fig. 2).

TDR has overspent on undesignated funding, resulting in \$9.2 liabilities for 2010/11:

- \$5.7m designated funding for specific activities has been spent in other areas.
- \$3.5m in arrears for the 2010/11 WHO administration charge.

It should be noted that the TDR finances are subject to audit scrutiny and no audit reports have found any evidence of lack of probity.

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The resulting liquidity issues have been addressed by prioritising activities and stopping research in non-priority areas. As a result, TDR will finish 2010/11 with a nil balance on its undesignated funding and a positive balance on designated funding for specific activities, but with \$9.2m liabilities.(i.e. WHO 2010/11 charge and activities for which designated funding was received and diverted to other expenditure, leaving the agreed activity unfunded).

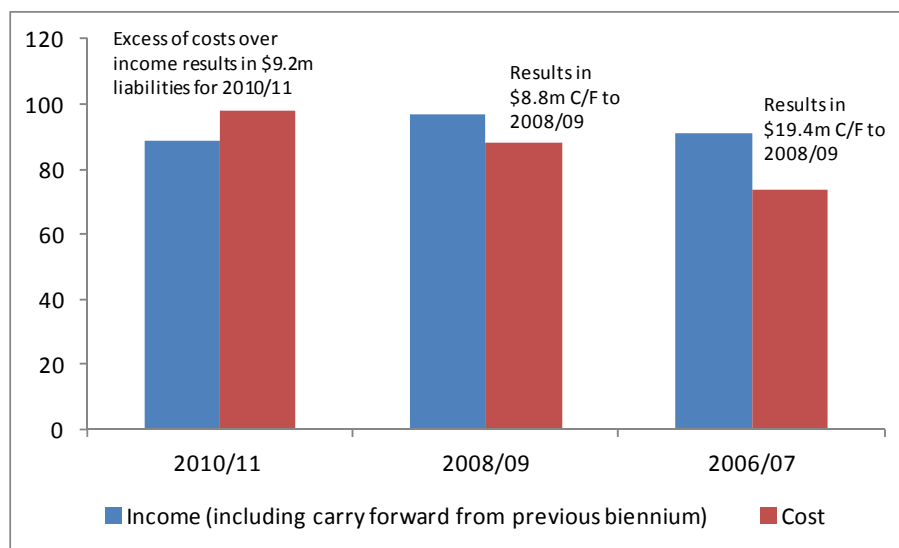
Table 1 Forecast Financial Performance 2010/11*

		2010/11	2008/09	2006/07
	\$m	\$m	\$m	\$m
Income				
Funding	76.5			
High probability income	3.5			
Total income		80.0	77.1	72.0
Expenditure				
Salary	39.2			
Programme Support	6.0			
Activities	38.8			
Subtotal	84.0			
Payment of 2008/09 encumbrances	4.8			
		88.8	88.0	73.7
Outstanding costs (not paid)				
Designated liabilities	5.7			
WHO 2010/11 charge	3.5			
	9.2			
Surplus/deficit from operations		-8.8	-10.9	-1.7
Financial revenue			0.3	2.3
Net surplus or deficit		-8.8	-10.6	0.6
Opening balance		8.8	19.4	18.8
Closing balance		0.0	8.8	19.4

Source: *2010/2011 are management estimates of income and expenditure (not audited). 2008/09 and 2006/07 income and expenditure have been sourced from the 2008/09 external audit report. Encumbrances are carried forward payments.

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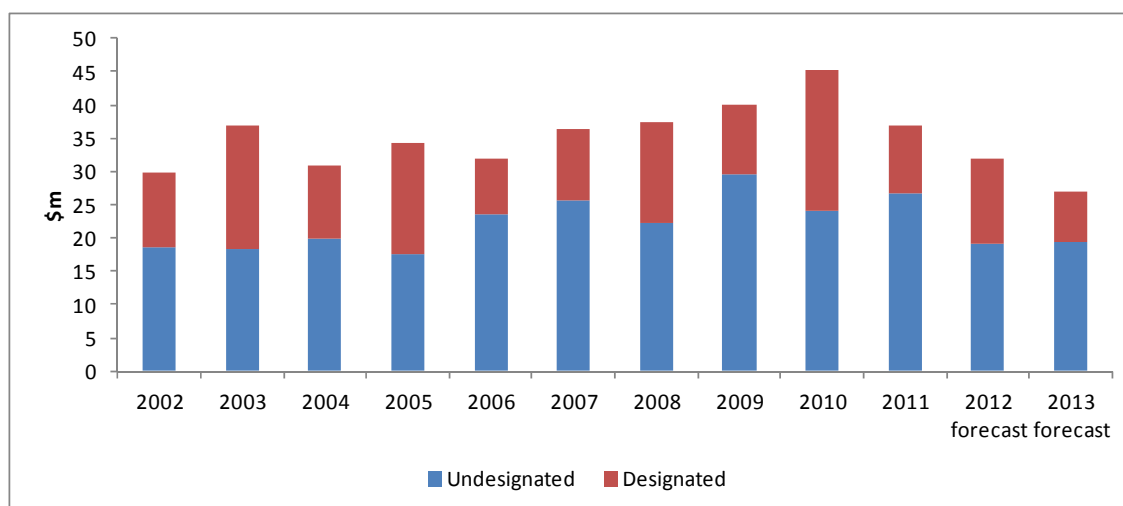
Figure 2 Graph of Income versus Costs (including liabilities) for 2010/11, 2008/09, 2006/07



4.3 Budget 2012/13

TDR has put forward a conservative budget for 2012/13 of \$70m. Although designated funding can vary significantly depending on specific opportunities, undesignated funding typically demonstrates a high level of visibility. Forecast income of \$70m for the 2012/13 biennium appears conservative relative to historic levels but it is recognised by the senior management team that there may be a confidence issues amongst funders (Fig. 3).

Figure 3 Designated and Undesignated Funding 2008-13



4.4 Cost Structure Efficiency

Personnel and programme support costs (fixed costs) have increased from 39% in 2006/07 to 50% in 2010/11 (Table 2). In 2010/11, personnel costs were inflated by currency factors estimated by Portfolio and Programme Management (PPM) at \$2.6m and restructuring costs associated with reducing staff levels estimated at \$1.7m. Both the estimates of restructuring costs and currency impact appear low and insufficient time was available for the review team to assess whether these are accurate. Excluding estimated restructuring costs, personnel and programme costs represent 49% of total costs.

Despite the restructuring, personnel and programme support costs are expected to remain high at 53% of expenditure based on the 2012/13 budget of \$70m. In addition, there is risk from any further strengthening in the Swiss franc relative to the dollar. Because of high overheads and one-off costs (including severance costs) in 2012/13, funding for activities will be reduced to a relatively low level of \$26.7m (37% of total costs), which includes \$5.7m for 2010/11 liabilities on specific funding.(i.e. the need to undertake designated work for which funding has been received but spent elsewhere without the work yet being done)

This level of overhead costs appears to be excessive. Feedback from informant interviews indicates that, as a maximum, 30% of total costs for personnel and programme support costs should be targeted.

Table 2 Actual and Forecast Income and Expenditure 2006-2011

	2006/07		2008/09		2010/11	
	Actual		Actual		Actual expenditure & estimated encumbrances	
Activities	44.6	61%	48.3	55%	43.6	49%
Programme support	7.0	9%	8.8	10%	6.0	7%
Personnel	22.1	30%	30.9	35%	37.5	42%
	73.7	100%	88.0	100%	87.1	98%
Reorganisation costs					1.7	2%
Total	73.7	100%	88.0	100%	88.8	100%

Because the restructuring in May 2011 was conducted in line with WHO standards and procedures, it seems that many of the redundancies were posts occupied by temporary personnel or personnel on short term contracts (Table 3) as this could be achieved more quickly and at lower severance costs. Despite the restructuring, staff costs remain high, raising questions over the effectiveness of the process.

It has been reported that the WHO system creates a bias against terminating long term contracts due to high redundancy costs associated with these contracts, which means that potentially the most effective people may not be retained. Feedback from interviews supports the view that a more radical restructuring may be necessary to create a more sustainable structure with the most effective people. Average staff costs have increased from \$12,000 per person per month in June 2010 to almost \$20,000 per month in July 2011 (PPM estimates), although some of this increase is attributable to currency factors. Considerable doubts have been raised about whether this level of monthly staff cost is sustainable in the context of the programme.

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Table 3 Fixed term and temporary contracts personnel costs

\$m	2010	2011	2012 (Budget)
Fixed term/Continuing	16.7	17.2	15.3
Temporary	3.1	1.3	0.2
Total	19.8	18.5	15.5

4.5 Undesignated funding needs

As highlighted in the section on budgeting and planning processes, a weakness of the current 2012/13 budget is that requirements for undesignated funding need to be accurately identified. In 2012, undesignated funding needs for personnel and programme support and payment of 2010/11 liabilities will total \$24.6m (Table 4), which exceeds forecast undesignated income levels of \$19.2m by \$5.4m. Therefore, based on current forecasts, insufficient undesignated funding will be available in 2012 to pay liabilities from the previous year and to finance activities which rely on undesignated funding. Excluding 2010/11 liabilities of \$9.2m and reorganisation costs of \$0.5m, forecast undesignated funding income of \$19.2m only exceeds personnel and programme support costs by \$4.3m. This means there is no undesignated funding for any activities once staff have been paid.

Forecast cashflow for 2012 confirms that inflows of undesignated funding will only be sufficient to cover existing personnel and programme support costs. Availability of undesignated funding for other purposes will be limited which will impact on the programme's basic mission.

Table 4 2012 Undesignated (UD) Funding Needs

UD funding needs in 2012 (\$m)		UD funding forecast in 2012 (\$m)	
Salary	14.7		
Reorganisation costs	0.5		
Programme support	3.4		
Salary/charges cover	-3.2		
Liabilities DF 2011	5.7		
WHO admin 2010-11	3.5		
UD needs total	24.6	UD forecast total	19.2

Source: PPM estimates

4.6 Recommendations

- Despite the restructuring, overhead costs as a percentage of overall costs and compared to forecast undesignated funding remain high. This raises questions regarding the efficiency and sustainability of the current TDR structure.
- Based on current forecasts, the 2012/13 budget and workplans will need to be revised in view of requirements for undesignated funding.
- There may be opportunities for efficiency and cost efficiency gains on existing support functions. For example, a merger of Communications and External Relations units could be envisaged to reduce costs and ensure that communications are aligned with donor requirements (lack of integration between external relations and communications units has been highlighted as a weakness in the communications section)

The Standing Committee has reviewed finances and will be agreeing a way forward.

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4.7 Overview of financial results

Note; the financial analysis has been prepared by HLSP from TDR documents and verified by PPM for consistency with their records, but require further scrutiny.

Table 5 Expenditure Analysis by Team 2008-2011*

			Cumulative
Activities	2008/09	2010/11	2008-11
Continuing Activities			
Stewardship Activities	2.7	5.4	8.1
Empowerment Activities	5.9	3.6	9.5
Innovation Network Activities	0.6	1.6	2.2
VES Activities	5.6	5.1	10.7
NTD Activities	8.0	5.1	13.1
TB/HIV	8.5	5.7	14.2
Malaria Activities	6.5	4.1	10.6
	37.8	30.6	68.4
Funds transferred to regions	3.7	2.5	6.2
Transitioned Activities			
Lead discovery for drugs	5.2	1.4	6.6
Diagnostics	3.8	3.8	7.6
Other research activities (eg. STI)	4.0	0.8	4.8
Total Activities	54.5	39.1	93.6
Personnel for Continued Activities			
Stewardship Personnel	2.6	2.9	5.5
Empowerment Personnel	3.9	2.6	6.5
Innovation Networks Personnel	1.9	2.3	4.2
VES Personnel	1.5	1.9	3.4
NTD Personnel	2.9	2.6	5.5
TB/HIV Personnel	2.1	2.0	4.1
Malaria Personnel	2.3	2.4	4.7
Programme Support	9.0	5.7	14.7
Additional Personnel (eg. QA, RMS)	3.0	2.2	5.2
Personnel for Transitioned Activities			
Staff restructured/left		8.3	8.3
Oct/Dec 2011 staff costs to be allocated		6.0	6.0
Other	0.8		0.8
Total Personnel	30.0	38.9	68.9
Programme Support	8.9	6.0	14.9
Total Expenditure	93.4	84.0	177.4

* Expenditures reflect IPSAS accounting practices whereby expenditure is reported according to the 'delivery principle' i.e. only when services have actually been provided rather than when funding are initially committed (encumbrances)

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4.8 Overview of Expenditure

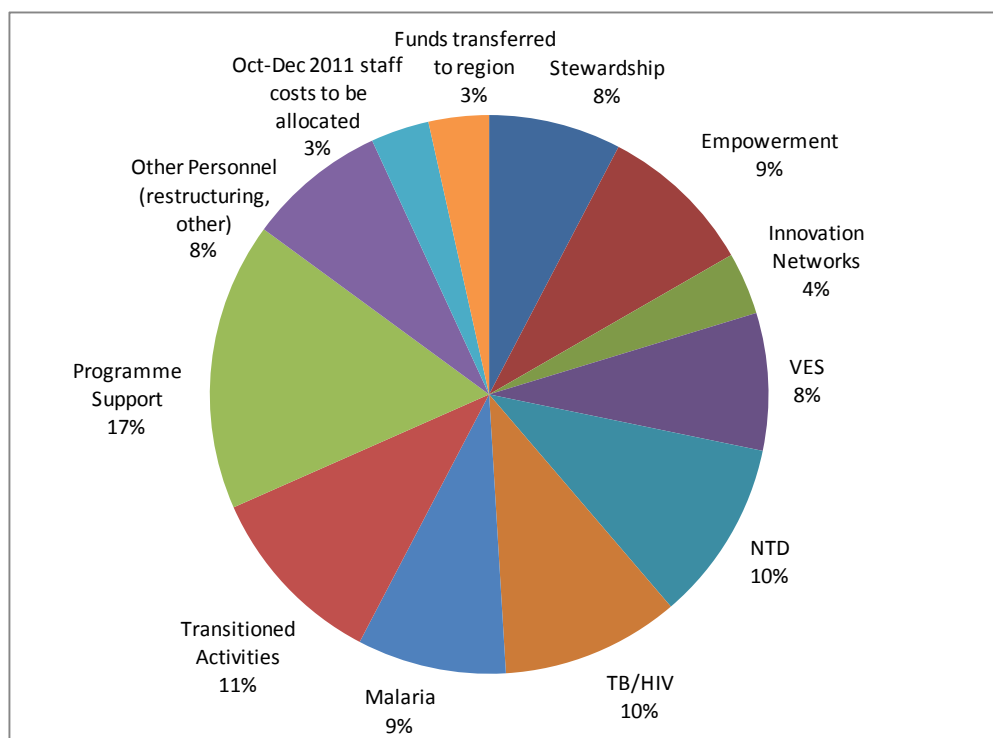
Total expenditure for the 2008/09 and 2010/11 biennia is estimated at \$177.4 (Table 4). The 2012/13 budget forecasts a 17% reduction in expenditure relative to the 2010/11 level of \$84m, to bring expenditure in line with income.

Out of total estimated expenditure for the two biennia 2008-2011, the Stewardship and Empowerment Unit represent approximately 21% (\$36.0m) (Fig. 4). Expenditure on continuing activities within the research unit (Vector, Environment and Society, Neglected Tropical Diseases, TB/HIV and Malaria) is estimated at 37% of total expenditure (\$66.3m). Activities transitioned (excluding personnel costs) contribute 11% of total expenditure (\$19.0m). Programme support costs, including personnel for programme support, make up 17% (\$29.6m) of total costs.

TB, HIV and malaria are a high proportion of TDR's budget yet, in comparison with global resources in these fields, are "a drop in the bucket". It is not clear what specific leverage is being achieved in these areas through this investment which raises the issue whether TDR has comparative advantage.

Financial analysis of expenditure for each major activity will be detailed under the relevant sections.

Figure 4 Analysis of Expenditure 2008-2011



5. Impact on the current review

In the light of the financial issues facing TDR early in 2011 and the subsequent rationalisation of the programme and restructuring, the current review will not match the pattern envisaged for the 2012 review. In the first instance, it is very much reduced in scope and timescale but inevitably the focus has been on governance, management, finances and the future areas of activity for TDR. The review, in part, attempts to capture progress on agreed activities arising out of the 2005-6 review and the subsequent Business Plan but many of these have been modified during the period 2008-11.

The review took place over a six week period from start to finish and reviewers have been interacting with the senior staff at TDR and the team leader attended the Standing Committee meeting in Berlin on October 25th. This has resulted in a more iterative process with preliminary findings from the review informing decision making, particularly in respect of the Standing Committee held on October 25th.

Whilst there was a recognition that, despite action taken earlier in 2011, there remained financial shortfalls, the analysis undertaken as part of the review shed further light on the current situation. Much of the financial analysis which arose, in part, from the review process was presented at this meeting and high level feedback was given on governance issues, the comparative advantage of TDR and issues relating to value for money (effectiveness and efficiency).

6. Governance and Management

6.1 The Relationship with the Executing Agency (WHO)

TDR was set up as a special programme under a Memorandum of Understanding (MOU) in 1978 and revised most recently in 2008. WHO is defined as the Executing Agency and thus employs all TDR staff under its standard contracts of employment (permanent and short term).

The Director of TDR is contractually accountable to the WHO ADG Information, Evidence and Research but it is not clear to what extent they have been held to account, both managerially and professionally in the past .

Part of the reasoning for TDR being a special programme, hosted by WHO, is the desirability of close collaboration with other parts of the organisation. The relationship is a mechanism for ensuring that research is fed into disease control programmes and guidelines. Historically the relationship with other WHO departments, notably NTD, has not been close and this was exacerbated by the physical move of TDR outside the WHO campus.

6.2 The Standing Committee

The Standing Committee (SC) consists of representatives of the four sponsors (WHO, World Bank, UNICEF and UNDP) who meet twice a year, together with the chair and co-chairs of the JCB and Chair of STAC. A third informal meeting annually takes place at the same time of the annual meeting of the JCB.

Sponsorship is difficult to define, despite the MOU. It does not necessarily imply any form of financial support or support in kind and, indeed, currently, there was only financial support from WHO and the World Bank. As hosting body, WHO clearly does make some contribution in kind but this is hard to quantify and disaggregate against the administration fees, the organisation levies and the benefits received , notably where TDR members working closely in WHO core departments (e.g. the Global Malaria Programme) There is no doubt that the involvement of the sponsoring bodies gives TDR credibility and standing and, particularly, that the close relationship with WHO has functional benefits, albeit not always fully exploited, in relation to implementation of science/ input into disease control programmes.

The Co-sponsors are tasked in the MOU as follows

“in cooperation with the co-sponsors of the Special Programme, the Coordinator will be responsible for the overall management of the Special Programme”

The Co-ordinator is the ADG of the IER cluster (WHO) who is also the normal representative of the WHO as a co-sponsor on the SC. The definition of co-operation is not clear and the exact overall management responsibilities (if any) of the other co-sponsors is undefined.

6.2.1 Role of the Standing Committee

The role of the Standing Committee is described on the TDR website as having oversight of TDR finances and management but its formal responsibilities and authority, as stated in the MOU, do not entirely accord with this definition. The MOU states that the SC reviews the plans and budget prior to the annual JCB meeting but it does not state that it has ongoing responsibility for monitoring throughout the year. Indeed, there appear to be no “non executive” checks and balances in place.

However, when interviewed, SC members felt that they “held the ring” on behalf of the JCB in oversight between meetings but it is difficult to identify any formal mechanisms for this which have been used systematically.

Some JCB members believed that the SC was actually the senior body with management responsibility and decision making powers. Whilst there was clarity that the Director was managerially and contractually accountable to the ADG (WHO), several JCB members believed that he / she was held to account by the SC. This is neither constitutionally nor factually the case and probably is beyond the managerial co-operation outlined in the MOU.

Furthermore, it is not clear to what extent the SC has decision making authority. At the spring meeting of the SC, the lack of clarity was recognised and it was requested that operating procedures be more clearly defined. Despite this, there was no clarification of the role and remit of the Standing Committee on the agenda for the October 2011 meeting although the matter was debated as part of initial feedback from the review.

6.2.2 Standing Committee Administration

Agendas have, in the past, been difficult to interpret with a lack of clarity as to the actions required by the members. This was recognised at the spring 2011 meeting and it was agreed that future agendas should specify whether items were for information, decision or discussion.

The October agenda gave some indication of purpose but there was a lack of clarity about what decisions were to be made and how decisions would be implemented (including responsibility for implementation, timeline and monitoring processes).

6.2.3 Continuity of Input

The SC was extended to include the chairs and co-chairs of the JCB and the Chair of STAC but it is inevitable, given their period of office (Chair JCB 2 years, Vice-Chair JCB 1 year, Chair STAC, up to 6 years), that there cannot be continuity in attendance. This is, to a lesser extent, also an issue for sponsors where analysis of recent minutes shows that in a two year period (meetings 84-89) there has been relatively consistent attendance from UNICEF and the WB but WHO and UNDP have had a number of people representing the organisations. The level of seniority of representatives appears to vary considerably.

Despite having financial and managerial oversight, the SC agenda has a high content related to information exchange but no standing items for monitoring performance against plan, expenditure against budget or income against projection.

6.2.4 Logistics

The SC meets in different locations: occasionally it coincides with international events. This is sensible only if it can be demonstrated that travel and accommodation costs can be reduced as a result. Given that the co-sponsors travel at their home organisations expense, the major cost to TDR relates to staff travel and therefore, from TDR's point of view, meetings in Geneva are most efficient. Current practice has been that the spring meeting is often in the US hosted by a co-sponsor whilst autumn meetings have been hosted by a major donor

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Although many people stated that there was also the opportunity for virtual meetings using VOIP or telephone conferencing, this does not seem to be used extensively. Most members of the SC have access to video conferencing.

6.2.5 Observations and Recommendations

The remit of the SC needs to be reviewed, clarified and disseminated, both internally and externally. (See Governance recommendations Section 6.5).

It is clearly advisable that good practice be implemented in respect of agendas and minutes. Agendas should be divided into items for decision, discussion and information. Members should be guided by the agenda as to the decision required and this may include providing a draft.

When minuted, all items should indicate any action agreed together with the timeline and the person responsible. These should be systematically followed up at the following meeting.

The meetings should routinely be held where there is demonstrable VFM.

It is recommended that more use be made of VOIP and video conferencing.

6.3 Joint Co-ordinating Board (JCB)

6.3.1 Role and function

There are significant differences of opinion about the role and responsibilities of the JCB. There is a real divide between the view that it is primarily a body to establish ownership among a range of stakeholders and a contrary view that believes it is the senior governing body for TDR with responsibility for all aspects of the organisation's functioning.

Examination of the minutes and discussions with attendees clearly indicates that, in general, much of the time of the JCB is expended on information receipt and ratification of proposals from the executive and/ or the SC. Given the size of the JCB, the lack of continuity of individuals attending and the frequency of meetings, this is perhaps inevitable.

The key official function of JCB appears to relate to ratifying the forward plan and budget and being the vehicle for pledges of support. Given events in the recent past, it would appear that the JCB provides no effective challenge to the reality of the planning and budgeting process. It has no role in ongoing monitoring and evaluation and has not been involved in setting corporate standards for TDR.

There is a considerable feeling that the JCB performs largely as a "ceremonial" function (some would go so far as to say rubber stamping). The counter argument is that it provides both an inclusive forum for agreeing strategic direction but also contributes to the stewardship and advocacy process and encourages the contribution of DEC's

6.3.2 Membership of JCB

The JCB has thirty four seats with some being shared between more than one organisation (constituencies). Interestingly, some of the significant funders are part of constituencies whilst there are countries who are neither DEC's nor major contributors who have a dedicated place. There are considerably more people who attend JCB meetings, however, including observers. This results in debate being formalised.

The JCB is much too large to be an effective management and co-ordination body although the revised membership now includes a wide range of stakeholders and the balance is more towards DEC countries (which is clearly commendable). DNDI will become a partner in 2012 being the first NGO or private sector member. However, none of the major non-governmental funding bodies (e.g. the Foundations) have a place.

There do not seem to be clear criteria for attendance and this appears to result in some attendees having little real input. Indeed, if the JCB was making major decisions, it could be argued that there would be a significant proportion of people making these decisions who were neither major funders, collaborating partners nor countries where work was being undertaken,. Whilst the prime aim may be to establish ownership, it is difficult to identify any evidence that the JCB contributes to this to any great extent as not all of the attendees have an in depth understanding of the field.

There remains considerable feeling amongst JCB members about the involvement of countries who are neither substantial funders nor DEC's. Some of these countries have benefitted substantially from work done by TDR in the past and are now not classified as Low Income Countries (LICs). There is a feeling that pressure should be exerted for recognition by them of past support given by TDR and that the continuing presence of these countries on the JCB should be re-considered. It is understood that some efforts have been made with China, India, Thailand, Nigeria and Brazil to increase their contribution as the sums received from them are small.

6.3.3 Agenda for JCB meetings

The agenda for Secretariat meetings follows a strict format and varies little from year to year. It is proposed by the executive some four to five months in advance and ratified by the SC. Given the time lapse there is little flexibility and the agendas do not allow time for meaningful interaction.

6.3.4 Logistics

Production of papers, logistics and circulation of invitations is transaction heavy. Some six hundred letters were reported as having been sent in accordance with WHO protocols. Translation has to be provided for meetings and production of papers takes several weeks.

6.3.5 Cost and Location of Meetings

Meetings are large and have, recent been held in alternate years in locations where TDR has major activities (China, Brazil etc.) Although funding partners cover their own expenses, the cost to TDR of these events is extremely high (in excess of \$500,000 in one instance). The total cost, including the contribution made by funding partners and the cost of time expended, probably doubles this. Approximately 20% of

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attendees were reported as receiving sponsorship. The last JCB cost was approximately USD 80,000 but even this figure is higher than the cost quoted to the team for a similar body..

6.3.6 Conclusions and recommendations

JCB is not currently acting as an effective governance body. It may have some function for advocacy, information exchange and resource mobilisation. It does not provide effective managerial control or challenge, largely because its role is neither formally clear nor understood by members.

Any review of the future role of JCB should be based on a careful analysis of what TDR's future focus and capacity is and what governance structures will best support this role. It should incorporate a review of membership and aim to widen the involvement of potential funders (both for designated and undesignated funding).

It is difficult to justify the expenditure on such extravagant JCB meetings even if they do incorporate relevant field visits, particularly at a time of financial austerity. It is understood that future meetings will be held at a lower cost venue. Consideration might be given to reducing the frequency to every two years and changing function so that it becomes a meeting of all stakeholders with a specific advocacy purpose (perhaps renamed as a Partners Forum).

Meetings should only be held away from HQ when there are demonstrable economies in so doing and the use of remote communication should be maximised.

Given some common membership, co-location and synchronisation with other similar special programmes/partnerships major events seems desirable. This was proposed some time ago but no effective changes have been made.

Although governance was reviewed recently, there appears to be a de facto case for a further review, rationalisation and clarification. (see governance recommendations)

6.4 The Scientific Technical Advisory Committee (STAC)

6.4.1 Role and function

The STAC is the senior scientific body of TDR and brings together leading health research scientists. It has three major functions:

- To review, from a scientific and technical standpoint, the content, scope and dimensions of TDR, including the diseases covered and approaches to be adopted;
- To recommend priorities within TDR, including the establishment and disestablishment of Scientific Steering Committees, Task Forces and Working Groups, and all scientific and technical activities related to TDR;
- To independently evaluate the scientific and technical aspects of all activities of TDR.

The STAC also advises on the use of funds to the JCB and to the TDR director.

6.4.2 Membership of the STAC

The STAC consists of around 20 scientists. Members are selected on the basis of scientific or technical competence. They serve for a period of two years and may be reappointed up to a maximum of six years. A number of members have served multiple terms on the STAC.

The current STAC has 21 members. STAC members are nominated by the Director of TDR and appointed by the JCB, in consultation with the SC. In 2011 a competitive process was established for replacing six members who completed a 6-year mandate. The number of applications for this indicates that the position is generally seen as a very prestigious one.

The selection process of the STAC seeks to balance members from social science research (including health economics), basic biomedical research (including product research and development), implementation research and health systems research and science, technology and innovation. The STAC also seeks to have a balance in terms of gender and regional representation. Some interviewees commented that the current composition is still too heavily focussed on the hard sciences, with too little representation from the social science, health systems, and health economics areas of interest. However, overall, the STAC is reportedly a valued and respected body.

6.4.3 Process and logistics

In principle, the STAC meets every year face to face. In 2011, because of the restructuring of TDR, the STAC for the first time organised a process of virtual meetings and consultations to discuss the 2010 report and provide inputs into the 2011 work plan. This included a process of electronic reviews and email consultations on various reports and products, as well as a teleconference to consolidate the comments. The fact that the STAC was not able to meet face to face was seen by some as a limitation to the quality of the dialogue and interaction.

The STAC meetings result in the production of a report which is organised by areas. For each area the report presents a summary of the findings, as well as clear conclusions and actionable recommendations.

6.4.4 Inputs by STAC into decision making

The 4th review noted challenges with the STAC being used to validate decisions by the management of TDR. This review finds that, in practice, the STAC continues to play an advisory, rather than decision making role to the JCB and the TDR director although there are occasions when this validation is sought. Documentary evidence and interviews highlight the fact that the STACs recommendations are not consistently taken on board, and that no proper feedback is provided as to why these recommendations are not followed. Systems have been put in place to track recommendations in the future.

"We have had a persistent view in the STAC that TDR was not doing a good enough job prioritising, that there was an unnecessary proliferation of business lines, and that much more careful reflection and streamlining was necessary". STAC member

In particular, budget reporting to the STAC has been neither accurate nor transparent and has not been consistent year on year making it difficult for the STAC to make good recommendations.

Various STAC members highlighted that concerns were raised by the STAC about the ambitious nature of the expansion plans in terms of human resource recruitment and budget forecasts but that these were

ignored despite being minuted. The STAC has also highlighted on various occasions the need for greater streamlining of the portfolio, i.e. noting that TDR was moving into new areas without moving out of the other areas fast enough. Again, in this area, advice has not been consistently followed through and this seems a result of over confidence that funding could be found ..

In the more recent phase, the STAC has played a major role in the restructuring of TDR providing, for example, extensive oversight and advice of the decisions related to the merging of the stewardship and empowerment areas. In the current context of reduced financial resources and downsizing of TDR, a closer relationship has developed between the STAC Chair and the management of TDR.

6.4.5 Conclusions and recommendations

The importance of the role played by the STAC and the quality of the work that is done, as well as the prestige it gives to TDR, suggests that the STAC should continue to function along the lines that it has had in the past.

The STAC is generally perceived as providing high quality considered inputs into decision making which reflect a careful analysis of the context and seek to use TDRs comparative advantage. It produces timely and well prepared inputs and reviews of the progress. The fact that it continues to be seen as a prestigious committee has allowed the STAC to benefit from the input of senior and experienced experts. The STAC has clearly provided value for money in terms of the quality of its inputs, and would have even higher value for money if its recommendations were consistently followed by actions on the part of TDR.

The effectiveness of the STAC as a mechanism is hampered by the lack of uptake of its recommendations by the JCB and up until recently, by a management approach of TDR which on occasions ignored the STAC advice for whatever reason. It is evident that there has not been adequate communication with STAC members when recommendations could not be implemented.

In order to enhance its effectiveness, TDR should prioritise resources to ensure the STAC meets in a face to face setting at least annually.

In recruiting new members of the STAC (and in light of the comments made by interviewees to this review on the composition of the STAC) the JCB and the SC should ensure that their endorsement of the candidates takes considered account of the need to ensure the 'right' balance of members to ensure adequate representation of the refocused priority areas of TDR.

TDR might consider, over time, working towards a smaller STAC with 12-15 carefully balanced members to reflect the areas that TDR will focus on in the future. It is important that such a process not be perceived as reducing the status or prestige of the membership of the STAC as this is a key ingredient of its success.

A careful and in-depth review of mechanisms for ensuring that STAC recommendations are reflected in reporting to the JCB and TDR management is needed. In particular, where decision making bodies of TDR decide to deviate from the advice given by the STAC, the reasons for this should a) be carefully documented; and b) fed back to the STAC as an input into their future deliberations.

6.5 Overall Governance Conclusions and Recommendations

There is a growing realisation that TDR is a body which has been subject to little effective management in the recent past. Whilst the Director has had significant autonomy, there has been a lack of clarity about accountability, responsibilities and prioritisation. Many decisions have been either aspirational, taken in an opportunistic way or based on pragmatism, sometimes without adequate access to meaningful analysis or consideration as to how the parts of the organisation relate to the whole and to its goals.

At a time when financial stability is crucial, it could be argued that reorganising the governance arrangements is a diversion. However, it is of equal importance to provide funders with the assurance that TDR is responding to recognition of shortfalls and putting in systems to ensure probity, effectiveness, efficiency and long term sustainability.

TDR is not a Global Partnership but was set up under an MOU as a Special Programme. Other bodies, which were initially set up as hosted organisations such as GAVI, MMV or FIND, have been recreated as Swiss Foundations with international institution status. This is felt to have increased their ability to respond quickly and flexibly and has put pressure to operate in a more business like way. Where this model can be combined with public charitable status, this makes these bodies attractive as the beneficiaries of foundations and endowments, for example.

In its current financial situation this option is almost certainly not available to TDR and, therefore, hosting appears to continue to be the appropriate model. Having WHO as the host agency makes most sense, given the need for synergy with WHO's normative function.

Other special programmes have similar governance frameworks but their structure is different. For example the Director of HRP is also Director of the complementary WHO programme on Reproductive Health. Given the less than close working relationships between TDR and WHO NTD Department, this option would seem less attractive for TDR in the short term.

TDR sits within the WHO cluster for Innovation, Information, Evidence and Research. Whilst this has some logic, there is equally an argument that consideration be given to relocating it in the cluster with malaria and neglected tropical diseases to enhance synergistic relationships.

TDR was set up under a MOU which is somewhat ambiguous and, it could be argued, needs clarification at least and renegotiation at most. This would be an opportunity to review and hopefully restate the commitment of the co-sponsors and to define their roles and contribution. To review the MOU will require legal advice and drafting as well as recommitment by partner organisations.

Neither the Standing Committee nor the JCB is working optimally. There appears to be a case to create a larger forum of stakeholders with a small Cabinet (in effect non executive board members) of the revised body who would meet quarterly with the executive (twice in person, twice by teleconference). This Cabinet would be the decision making body of the organisation and would hold the executive to account for activities, financial performance and professional standards.

The model envisaged is of a body with executive and non executive members with the NEDS holding the executive to account. The Director would be accountable to the "chair" of the Cabinet who would probably continue to be the WHO ADG. The Director is, in effect, the Chief Executive Officer figure.

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The JCB could be recreated as a stakeholder forum which would hold meetings of the wider stakeholder body perhaps each two years rather than annually, with an emphasis on advocacy, consultation, resource mobilisation and communication of achievements.

Membership of the Cabinet should not exceed a maximum of ten people and might be constituted as follows:

- Standing members who would include WHO and one or more co-sponsors
- Chair of STAC and JCB(stakeholder forum)
- Rotational members identified for a period of 4 years who would rotate on a 50; 50 basis every two years to coincide with the stakeholder forum (to give institutional memory and continuity)
- Senior level finance input from WHO (to provide oversight of the input from the TDR finance function)

Consideration needs to be given to the method of selection but this would need to involve the stakeholder forum and members would need to commit to the time involved and to bring appropriate competences in management and/ or knowledge of research. Lessons on methodology might be taken from other similar bodies.

The Cabinet would have a clear remit to hold the Director and the senior executive team to account for delivery of objectives and would receive regular monitoring reports covering activity, achievement of agreed quality standards and finance. The exact division of responsibilities with WHO as the executing agency needs to be clarified but the Cabinet would be responsible for

- Agreeing strategy (after consultation with the Forum)
- Agreeing the operational plans in line with strategy
- Selection of the Director (recognising the role of WHO as the employing body)
- Performance management of the Director (objective setting and appraisal) in partnership with the ADG (WHO)
- Overview and monitoring of activity against plan, adherence with quality standards and finance
- Reporting to the Stakeholder Forum

The STAC appears to be fit for purpose and there would seem no reason for major change apart from ensuring that future membership is aligned with the refocused core purpose of TDR and possibly downsized. It is important that advice given by the STAC is transmitted to the SC/Cabinet and that feedback is provided in the case of it not being accepted.

6.5.1 Summary

The review team recommends that TDR remain a hosted organisation under the auspices of WHO but under a revised MOU and governance arrangements.

Consideration should be given to:-

- Relocation of TDR in the same cluster as NTD and malaria

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- Establishing a “cabinet” with a clear remit for strategic decision making, operational planning, holding the Director and senior team to account, monitoring of agreed activities, financial performance and adherence to quality standards.
- Revising the frequency of Cabinet meetings (actual and virtual)
- Revising the remit of the current JCB so that a Stakeholder Forum is created with a role in advocacy, resource mobilisation, strategic consultation and information exchange which meets every two years

Legal advice may be necessary to obtain clarity on a process for revision of the governance arrangements and it would probably need agreement from the co-sponsors and current JCB.

7. TDR Operational Structure and Processes

7.1 Structure

The organisational structure of TDR has undergone major changes in the period covered by the review. Firstly, a restructuring and expansion programme was undertaken to create the Business Line structure. This appears to have been less than successful with some business lines consisting of as few as two people. It is reported that it further encouraged “silo” working and reduced synergistic working despite some of the business lines being “cross cutters”.

Prior to the restructuring, monthly senior management meetings have been described as “information meetings” due to the size of the senior management group. The only person with an overview of financial and management issues appears to have been the director. Limited financial management information was produced to monitor expenditure relative to income or budget, or to forecast cash flow requirements.

7.1.1 Position of Director

In the past, TDR has been fortunate in attracting a number of excellent Directors who have raised the profile of the organisation, achieved agreed objectives and attracted increasing funding. At the time of the review, the post of Director was vacant and being advertised.

Whilst the process for the recruitment of a new Director is outside of the scope of this review, it has been inevitable that both internal and external stakeholders have commented on the competences they feel are essential in the new appointee. There appears to be a difference of opinion as to whether there is currently a need for a person who is primarily a respected and high profile scientist with an active research interest or whether there is a need for a strong manager with knowledge of the research environment. At the request of the JCB, the job description was strengthened managerially.

On balance, there appears to be a preponderance of stakeholders who feel that there is an immediate need for a person who can refocus the organisation, ensure appropriate systems are in place for financial probity and planning, strengthen performance management and be entrepreneurial in seeking financial support. The feeling was strongly expressed by several interviewees that there was a need for the new Director to ensure that the competences and special interests of staff matched the portfolio of activities identified for the future. This may necessitate a degree of staff rationalisation but also recruitment in core fields.

Given the differences of views and challenges anticipated in the immediate future, it will be necessary to appoint a Director with the specific leadership and management competences to “turnaround” the organisation. They would still need to have research credibility but the main task will be to refocus, prioritise, embed control systems and align resources to objectives. It should be recognised that the task of restructuring will be made more difficult by WHO procedures and agreements with staff organisations and restructuring, whilst possible can be both expensive and time consuming.

There is a fairly wide spread perception that the Director and TDR staff potentially have the opportunity to promote research in their own area of interest. It is not possible, or probably desirable, to confirm or deny this but it is of the utmost importance that the new Director can demonstrate impartiality both in relation to research areas and to investment in institutions and locations. If TDR is to continue to have a convening function it will further be necessary to ensure that TDR is perceived as being a neutral platform.

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The Director is accountable to the TDR Co-ordinator (ADG WHO) and is subject to WHO processes for performance management and appraisal. It does not seem that co-sponsors or the Chair of the JCB have been involved in identifying objectives nor in providing performance feedback. It is difficult to evaluate to what extent Directors have been managed in the past but the impression is that they have been given significant autonomy and not held to account. Whilst the line management responsibility is clear, there would seem benefits in a greater involvement of co-sponsors and the Chair of JCB (or the Cabinet if such a model is adopted).

It should be recognised that there is value in the Director having the ability to mobilise relatively small amounts of money quickly and flexibly. This has been a valuable resource for previous Directors and should not be discontinued. There should be agreement about the overall limit on such funding and that it is for non recurrent grants and expenditure not for establishing recurrent commitments like increased staffing.

Traditionally TDR has been led by a scientist with significant research credentials. This has given the organisation credibility, ensured that the highest quality standards are met and contributed to the convening power of the programme particularly among leading scientists. Increasingly, the Director will have a major role in resource mobilisation which will require both advocacy/ influencing skills but also the ability to demonstrate value for money and potential impact.

TDR is more than a research organisation and has significant roles detailed above but also in communication, capacity building and as a convenor. No single Director can have all of these competencies and it is therefore essential that a whole team approach is taken, with the team measured against an agreed specification of team competences and any weaknesses or omissions addressed.

7.1.1.1 Observations and Recommendations

The selection criteria for future Directors should encompass both strong science and managerial competences and the opportunity should be taken to undertake a competence audit of the entire TDR team to ensure that all key areas can be delivered.

Consideration should be given to involving the Chair of JCB and co-sponsors (or the Cabinet or similar body) in objective setting and appraisal.

7.1.1.2 Senior Management Team

It has been reported that streamlining of the senior management team to just four people (the Director, the Research Coordinator, the Stewardship and Empowerment Coordinator and the PPM Manager) has improved decision-making and communication. This seems likely in that the span of control of the Director has been reduced. There have been significant improvements to address weaknesses in financial overview and the PPM department should be congratulated. Reports summarising the financial situation are regularly produced to inform SMG meetings and monitoring of monthly income and expenditure has recently been introduced.

However, the financial overview function and management accounting systems need to be strengthened further and there is a strong case for creating a senior position of Finance Manager.(see Section 7.2) There is a need for excellent, costing, pricing, forecasting and financial modelling skills together with the ability to ensure that cash flow is managed, changes in exchange rates are factored in on an ongoing basis and that the management accounts coding is fit for purpose.

7.1.3 Unit Teams

The roles and responsibilities of the coordinators, team leaders and support areas are not seen to be adequately defined. This limits effectiveness and accountability of financial and technical overview at all levels of the organisation. There is not a culture of accountability in the organisation and it is reported that even where scientists have responsibility for projects they tend to leave management tasks to administrative and secretarial staff. It is of the utmost importance for TDRs credibility that quality standards are set by co-ordinators and confirmed by the “Cabinet” and monitored. Team leaders are held to account for complying with these.

7.1.3.1 Team competences

It is essential that the senior team has the appropriate competences to deliver the full scope of TDR work. In the past, the prime requirement for many posts has been research knowledge and skills. However, it would seem that some posts need more than this. For example, there is a strong case for the postholder with a responsibility for empowerment/ capacity building to have significant knowledge of policy issues, of organisational development and the theory and practice of effective individual personal development as well as an understanding of research.

As a result of the need to reduce staffing, a number of people have been placed in posts which are new to them. It would appear that, in some cases, this placement has been based on expediency rather than ensuring that the post is filled with a person who can meet the requirements of the job. This is, in part, due to the strength of WHO staff association. Whilst the financial reasons for this are understood (although in practice keeping on long service staff may actually not be economically sensible), it does not contribute to team morale nor to the credibility of the organisation. If TDR is to be effective in a new “leaner” format then all staff must meet the competence specifications for their post.

7.1.4 Recommendations

- The revised structure of the SMG appears effective
- Both SMT and staff meetings should focus on regular monitoring of expenditure against budget and activity against plan. The planning process should drive the organisation and all its activities. This is not to say that TDR should not be opportunistic and flexible but this should be exercised with a full understanding of the costs and benefits.
- There needs to be strengthening of management accountability at all levels
- An audit of team competences against an organisational competence framework is needed.
- Every effort must be made to ensure that staff recruitment/re-organisation is done in such a way that staff meet the competence specifications for their post and that the full staff complement meets the needs of the organisation

7.2 Management responsibility for Finance

Financial management processes have been inadequate. There has been no clarity about who carries personal responsibility for any given budgets. Few financial reports are produced regularly for team leaders or coordinators, and limited processes for systematic review of project or team finances are currently in place. Monthly staff meetings provide a large forum that may not be appropriate for detailed technical or financial monitoring of projects.

7.2.1 Recommendations

- There is a need to strengthen the TDR with the addition of a qualified finance manager.
- Roles and responsibilities of SMG, coordinators, team leaders and support areas should be clearly defined to improve accountability and responsibility for financial and technical management at all levels of the organisation. Regular production of financial reports for projects would aid this preferably showing both commitment and actual expenditure
- Financial systems need to be strengthened, including production and review of management accounts, and cashflow forecasting (for designated and undesignated funding) to ensure that resources are sufficient and that there are no timing/liquidity issues.
- Budgets need to be profiled to show month on month expenditure forecasts
- Income projections likewise need to be profiled.
- The management accounting system needs to be able to apportion staff costs against specific pieces of work to ensure that allocated time is charged to designated projects.
- Periodic review processes for portfolio and teams are recommended, covering both technical and financial aspects. This would include mid-year reviews of progress and expenditure relative to budget and income.

8. Systems and Processes

8.1 Performance Management

A performance evaluation framework for the Programme and teams has been developed. Key performance indicators reflect three areas: achievement of scientific and strategic outcomes, application of core values, and management performance. The M&E framework was developed through a year-long participatory process in 2010 and the first report produced but its use so far is reportedly limited. Few systems are in place for monitoring of individual performance.

WHO has a personnel management and development system (PMDS) but its use is irregular. Staff indicated that there was not a rigorous and consistent process in TDR. This may, in part, flow from individual Directors but it appeared to be systemic . It is important that there is a system for setting both professional and managerial objectives for the Director and holding them to account. This does not appear to have happened in the past. Only when the Director has specific, measurable, timebound objectives can the system cascade through the organisation.

8.1.1 Recommendations

- The M&E framework that has been developed appears underused. Limited information is published in the annual reports. Progress against targets and budget needs to be reviewed and utilised to inform team planning.
- An objective setting and appraisal process needs to be implemented with the new Director. Agreement will need to be reached who will undertake this exercise in addition to the contract line manager (ADG WHO)
- Systems for individual performance evaluation should be strengthened throughout the organisation and aligned with evaluation of team activities.

8.2 Planning and Budgeting

The Portfolio and Programme Management (PPM) unit is responsible for planning and budgeting processes. Prior to 2011, funding ceilings are reported as having been allocated to business lines by the Director, rather than through a systematic allocation process. It is evident that allocations were, in a number of cases, based on poor costing and there did not appear to be an agreed costing model in place which was universally used. Scientists then submitted plans for use of funds which were reviewed as needed or at least at annual portfolio review meetings and formed the basis of the budget

Limited transparency in the allocation process was compounded by a tendency for individuals to negotiate on ad hoc basis directly with the Director on specific funding cases. In addition, no formalised portfolio review took place during the year to monitor whether expenditure matched budget or whether any changes to budget were required in view of income levels or progress on activities.

8.2.1 Changes implemented

For 2012/13, this process has changed. Results-based planning is being implemented as part of a WHO-wide initiative to improve resource allocation, transparency and accountability. In a process similar to applications for grant funding, teams submit requests for funding attached to specific outcomes and activities. Workplans were presented on this basis for the first time at the annual portfolio review meeting in September 2011.

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Prior to 2011, the budget was set at an aspirational level and did not realistically align with forecasts for funding. The 2012/13 budget is set at a relatively conservative level (\$70m) relative to previous biennia. However, insufficient undesignated funding is forecast to cover all costs in the 2012/13 budget despite plans to change the costing model and ensure that externally funded projects (designated) are charged for those core costs expended including staff and a percentage of overheads. Prioritisation of expenditure on activities will therefore be necessary and is being reviewed by the SMG and SC.

8.2.3 Observations and Recommendations

- Budgets need to be set at realistic levels, with the potential to adjust them if additional funding is received.
- Workplans need to be set in line with the budget for resource mobilisation. All funding requirements, including requirements for undesignated funding, need to be adequately planned for.
- A costing model needs to be agreed by TDR with advice from WHO so that designated pieces of work incorporate a share of fixed costs proportionate to input.

8.3 Priority setting and risk management

Prior to 2012/13, there was no systematic process for priority setting or risk management. Priority setting at the portfolio level was carried out by the Director and SMG acting in line with recommendations from STAC. In parallel with introducing results based planning, PPM is developing a new tool to prioritise projects according to strategic relevance (impact), risk, and cost. The aim is that this tool will inform funding allocation decisions and improve the transparency and efficiency of the planning process.

The key criteria defined to assess impact and risks are as follows:

Criteria for assessing impact	Criteria for assessing risk
<ul style="list-style-type: none">■ To a large extent builds capacity in DEC health research■ Has the potential to contribute an important impact on disease burden■ Has potential to have a significant impact on global health policy, strategy and priorities■ Has high potential to leverage resources from donors and partners■ Contributes to TDR competitive advantage	<ul style="list-style-type: none">■ Risk related to project design, implementation and delivery■ Risk to TDR image (reputational risk)■ Risk related to stakeholders and partners■ Financial risk■ Social and Environmental risk

The current system assesses risk and enables a mapping exercise incorporating risk, cost and strategic relevance. This is a potentially valuable tool for priority setting. However risk assessment is not valuable without risk mitigation. Standard risk management processes score initiatives for latent risk, identify ways in which risk can be mitigated and thus can score for residual risk. There is normally a process whereby initiatives with a residual risk above an agreed score are regularly reviewed at senior level. This is achieved by the development of a risk register which is regularly reviewed and updated. It should not only cover projects and activities but also routine processes.

At the business line or team level, priority setting was supposed to be driven by the Scientific Advisory Committees (SACs) attached to each business line and comprising key experts in the relevant field of research. SACs met up until late 2010 but then their work was suspended due to the funding situation and initiation of the restructuring process

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A proposal has been made to reduce the number of SAC from 11 (one for each business line) to two (one for the Stewardship & Empowerment, and Research units). These SACs will retain responsibility for priority setting and overview of unit progress but will not be responsible for detailed operational review of grants, awards and reports. The aim is to reduce costs and improve decision-making and accountability, by removing the ambiguity between management and advice bodies.

8.3.1 Changes implemented

At the portfolio level, the development of a prioritisation tool to inform the allocation of funds is perceived as a welcome development by staff, which will contribute to improving the transparency and efficiency of resource allocation in line with strategic objectives. The introduction of a clear process for fund allocation should contribute to improving the standard of planning. However, both internally and externally to PPM, there is agreement that this is just a tool and that criteria need to be endorsed and driven by strategic objectives set by the STAC. This does not remove the need for strategic allocation decisions, for example regarding the proportion of funding to be allocated to capacity building and to research, or the proportion of funding allocated to LICs versus MICs.

At the unit and team levels, the reduction in the number of SACs to two with a wide portfolio remit (3 teams for Stewardship and Empowerment, 4 teams for Research) should improve cost efficiency and decision making but specific expertise may not be available on the SACs. This initiative was agreed during the course of the review and it was therefore not possible to assess its potential in detail.

8.3.2 Observations and Recommendations

- The priority setting and risk management tool needs to be further developed and endorsed by the STAC and SACs to ensure that criteria are in line with strategic objectives. Its use in the decision making process would contribute to ensuring a transparent and efficient planning process. High level resource allocation decisions, for example regarding the proportion of resources to be devoted to research, and to stewardship and empowerment, still need to be made.
- Risk assessment needs to be extended to a process of risk management at all levels. This should involve each risk being the responsibility of a named person who has responsibility for active mitigation of risk. Risks should be documented in a risk register and risks with a residual score above a given level should be accelerated to the SC (Cabinet)
- Given the wider remit of SACs, processes need to be put in place to ensure that team activities are systematically reviewed and prioritised, and that procedures exist to inform SACs of high level issues. Access to specific fields of expertise needs to be retained (TDR are looking at the possibility of establishing an expert panel from which specific project teams can be drawn). Means of communication other than face to face meetings could fruitfully be explored

8.4 Financial Systems

8.4.1 Global Management System (GSM)

In terms of tools for project management and financial overview, the WHO-wide GSM records and management information system is accessible to all users and could potentially provide relevant information, but is not well used by team leaders. Historically, a TDR-specific management accounting system (WAAC) which downloads financial data from GSM into user-friendly financial tables has been used by PPM but is limited in scope and creates a parallel financial system. A new and complementary system to GSM, CONNECT, is being developed in conjunction with the Special Programme of Research,

Development and Research Training in Human Reproduction (HRP) to provide a user friendly system for portfolio and project management. It will replace the current information management system at TDR and HRP, TIMS (TDR Information Management System) incorporating areas such as procurement, contract and training grant management, and also new areas as contacts, portfolio performance, document and events management.

GSM does not take account of expenditure internally approved but not yet contracted. Requests for funding are approved under a separate, parallel system (RUF). Because requests for funding undergo an approval process outside of the GSM system, financial balances in GSM do not take these internal approvals into account. It is recommended that GSM, not RUF, be used for approval to ensure that a single system is used. It will improve accuracy and efficiency.

A key weakness of TDR's financial system has been the allocation of a single funding code (account) to all undesignated and designated funding, which meant that designated funding could temporarily be used for different purposes than intended. In effect all income was put into a single "bucket" (the Trust Fund). The system was designed to optimise flexibility of funding and to ensure that project needs were covered as they fall due. It was a way of bridging lags in cash flow but it was not recognised that it could only be used safely if there were firm pledges of funding to cover all planned expenditure, if there was accurate costing and excellent cost control and if both income flows and commitments/ expenditure were monitored constantly. This could not be done without the ability to have specific function and project codes.

There is general agreement that the practice which had been accepted for some time whereby carry over funding was used for expenditure in the early months of the year and resources were used flexibly without specific designation has led to the situation where there are currently \$5.7m liabilities for specific funding accumulated by end 2010/11. In effect, this means that designated funding has been used for other purposes and TDR is now unable to deliver the activities agreed.

8.4.2 Changes Implemented

The new PPM management has created specific codes for designated funding that ring fence it from undesignated funding and ensure that designated funds can only be used for the intended purpose.

Other weaknesses in financial control are also being addressed. For example, in addition to being set at too high a level, the 2010/11 budget was reported to be insufficiently detailed (shown at the level of the business line rather than at the task level in the financial GSM system). As a result, specific requests for expenditure could not be accurately tracked and monitored by PPM against budget, which was felt to have weakened checks on possible over expenditure on projects.

8.4.3 Recommendations and Observations

- Whilst flexibility is desirable to bridge gaps in cash flow, systems need to be put in place to ensure that expenditure never exceeds projected income. One way of doing this is the introduction of a Work in Progress (WIP) system. This would mean that the SMT would need to monitor every month that WIP did not exceed firm forward pledges.
- Expenditure committed but not contracted should be captured in project management systems to ensure accurate financial overview
- In general, designated funding should be earmarked to ensure that designated funding is used for the right purpose.

- Training in GSM and/or CONNECT is recommended to ensure that team leaders and project managers are able to use the tools and systems available.

8.5 Costing

Costing of projects/ grant applications has been inadequate and not undertaken to an agreed model. The cost of staff and overheads has not been consistently applied. There is no single tariff for costs such as travel and accommodation. This inevitably means that, if specific designated activities have been under estimated, they have to be subsidised by undesignated resources.

8.5.1 Recommendation

A costing model needs to be agreed as a matter of urgency and consistently applied. This is a technical exercise and will need professional financial input.

8.6 Resource mobilisation

Resource mobilisation is the responsibility of the External Relations and Governing Bodies (EXG) unit which is part of the Director's Office. TDR funding derives from three sources: the governmental and international public sector, the philanthropy/NGO sector, and the private sector. Most of the contributions from governments are undesignated or broadly designated, while the contributions from private foundations and NGOs are usually designated for specific projects.

In terms of undesignated funding, TDR benefits from relatively stable contributions from a small number of core government donors. Changes can occur, as for example in 2009 when contributions from the UK increased to \$7.4m from \$2m in 2008. Pledges from other government donors have remained relatively steady over the past few years. In 2011, TDR received additional contributions from Sweden and Japan in response to its appeal for further funding..

Designated funding opportunities are usually initiated by teams for specific projects. Grant application and reporting processes are covered in the next section. Designated funding can vary significantly year on year depending on the pipeline of opportunities (Fig. 4).

The 2008-2013 business plan targeted an 8% increase in annual funding from \$50m in 2007 to \$80m in 2013, with 30% contribution from the philanthropy/NGO and private sectors by that date. Current levels of resource mobilisation (\$36.9m in 2011) remain significantly below this target. In 2011, 17% of funding was derived from the NGO, philanthropy and private sector, which is significantly below the 2013 target of 30% in 2013, and is also lower than the 20% achieved in 2007.

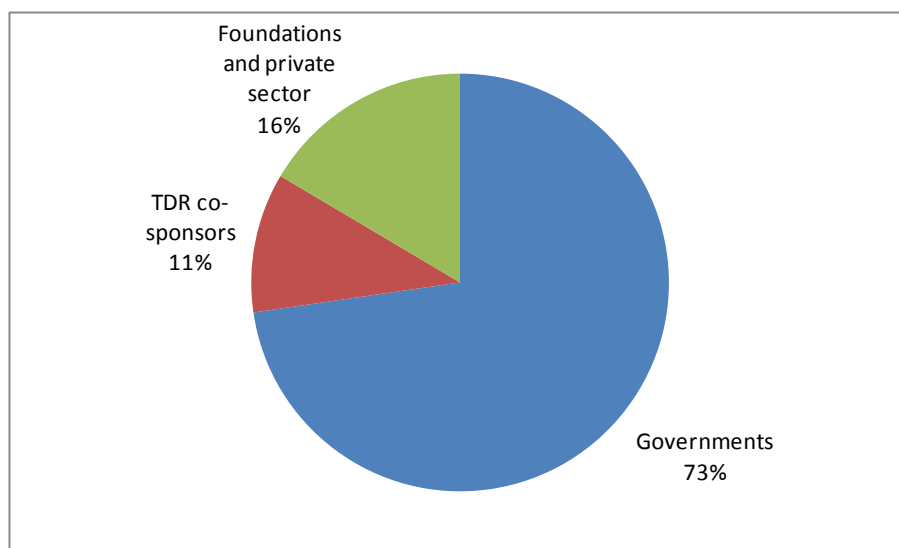
Overall, undesignated and designated funding levels in 2008/09 and in 2010/11 are consistent with prior year results. Although there was a major increase in designated funding in 2010, which increased its proportion as a percentage of total funding to 47% for that year, this trend was reversed in 2011 when designated funding contributed just 28% of total funding.

TDR is pro-actively seeking funding opportunities with new donors. For example, emerging economies that have benefited from TDR funding in the past are being approached. In the private sector, TDR is exploring the option of creating a foundation to attract contributions from wealthy individuals. New specific funding opportunities are also being sought, although efforts are reported to be limited by resource constraints.

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In order to optimise opportunities for resource mobilisation, it is important that TDR aligns its objectives within the global development framework and is able to demonstrate value for money by highlighting outputs and outcomes.

Figure 5 Analyses of 2011 Funding by Donor Type



8.6.1 Recommendations

- Identifying tangible outputs and outcomes, as well as improvements in efficiency (% personnel and programme support costs against funding of activities) that demonstrate value for money would be likely to increase TDR's success in resource mobilisation.
- Lessons could be learnt by examination of the funding sources of similar bodies. Foundations are known to have formed a higher percentage of their funding overall yet there does not appear to be a targeted initiative to see how TDR could win a proportion of this.

8.7 Grant application and reporting processes

8.7.1 Application

Extramural grant applications by TDR are usually initiated by team leaders. Specific funding opportunities may also be communicated to teams by the External Relations unit. It is not clear how decisions are made as to which applications are pursued. Given that, in the past, a number of grants have been accepted for work which is not core to purpose, there is a feeling that some decisions were purely opportunistic. There is agreement from the current senior team that, in the past, the main criteria for submitting some applications was income generation not content.

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8.7.2 Grant reporting

The Portfolio Officer and the team leaders are responsible for the technical aspects of donor reporting on undesignated and undesignated grants respectively. The finance officer is responsible for financial reporting.

8.7.3 Conclusions and Recommendations

8.7.3.1 Grant applications

Variations in proposal quality and success rates have been reported, indicating that existing quality assurance and sign-off procedures may be insufficient. PPM is developing a grant proposal review process to improve the quality of proposals and increase the success rate. Critically, no accurate costing system exists, potentially resulting in cost underestimates and creating liabilities that need to be covered by undesignated funding. In particular, the input by TDR staff has been underestimated or omitted leading to the need to subsidise from undesignated funds.

There has not been any system for risk assessing potential grants

8.7.3.2 Grant reporting

Weaknesses in grant reporting have been reported with instances of missed deadlines and a low quality of reporting. This is not the case across the portfolio but suggests a lack of systems and reporting QA.

8.7.4 Recommendations

- All projects should be subject to review with regard to their alignment with the TDR mission.
- An accurate project costing system needs to be developed to ensure that all costs are accurately captured and planned for, and checks need to be implemented to ensure that sufficient resources exist to cover these costs
- Improvements to the grant proposal review process may be helped by training in costing and application procedures
- All projects should be subject to risk assessment before application is made and major grant applications with high unmitigatable risk may need to be approved by the SC/Cabinet.
- Systems and processes for grant reporting need to be strengthened. The use of designated funding codes in GSM will help financial reporting.

8.8 Communication Systems

8.8.1 Background

The fourth external review highlighted a number of issues around communication, including:

- The need to significantly improve communication between TDR and other organisations
- The absence of adequate structures within TDR to ensure regular communication and coordination of the research capability strengthening (RCS) activities
- Lack of openness and poor communication with other WHO programs, at central as well as regional level; and

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- Insufficient systematic communication with the Regional Offices.

A specific communication and advocacy strategy for TDR – the first of this kind - was formulated in 2009 to support the new TDR 10 year strategy (which is silent on communication issues) for internal and external communications. This strategy underscores that communication and advocacy should support the overall vision of TDR and focus on:

- Increasing awareness of the renewed TDR and the value of its changes
- Empowering TDR staff and partners to communicate and advocate for this vision and approaches
- Supporting resource mobilisation for TDR research and advocacy
- Providing communications systems, tools and support so that research evidence reaches a wide range of target audiences, is translated into policy, and used for better health care

The 2007 TDR business plan also contained a number of organisational changes aimed at giving communication and advocacy a stronger role and making it more visible and integrated within TDR. This included positioning communications directly under the director's office - together with external relations and governance - so that both have a supportive role to the four functional areas of TDR. The communication strategy is explicit in highlighting that communication needs to be mainstreamed across all areas of TDR.

In this structure, the communication unit itself includes an overall manager and three key editor positions to cover the areas of general/advocacy, scientific documents and the website. The understanding is that each of these staff position work directly with the functional areas of TDR for the purpose of publications, and for the planning and support to specific communication events, outreach and advocacy initiatives.

The next section first reviews the progress towards the deliverables that are highlighted in the TDR communication strategy, and then discusses the overall strengths and weaknesses of the communication and advocacy area as identified through the present review.

8.8.2 Observations about communications

TDR communicates about its work and research results in a variety of modalities. This includes the publication of articles in peer reviewed scientific journals, TDR scientific publications, the TDR news letter "TDR news", as well as through its TDR scientist list (which is restricted access), and its overall website. TDR also participates in multiple events, including in the organisation of global meetings and conferences.

There has been a focus on improving communications in the current period in line with the recommendations of the 2005/6 review, with a restructuring as outlined above, recruitment of additional staff, and the development and implementation of a specific communication and advocacy strategy for 2010-2012. There has been a strong focus on collaborative communication with other partners (e.g. by collaborating in the organisation of global meetings and events with COHRED, the Alliance for Health Systems Research, WHO, Global Health Council, and Research! America).

In terms of activities over the review period, the focus has been on improving the communication around research findings to various target groups, broadening advocacy to include funders and policy makers, and more closely linking research to policy. This has included ensuring that communication is built into research from the beginning; improving the identity and visibility of TDR; and highlighting TDR's unique contribution and focus. Work has also been undertaken by the Communications unit giving TDR a clear face and creating a tag line "TDR making a difference", developing key messages, presenting both in-depth and

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short pieces, having a directors' letter included – all changes aimed at sharpening the communication and making it more effective.

Finally a number of actions were taken to address the issues raised by the last review. This has included much more systematic communication and planning with WHO regional offices, collaboration with partners on key events (see below), closer integration of research with other partners (e.g. malaria within WHO).

8.8.3 Implementation

A number of the activities that were foreseen in the strategy have suffered from funding shortage (see table). Overall, over the period, two of the four staff positions have been discontinued as part of the 2011 rationalisation. Some of the work is now done through short term consultancies.

8.8.4 Progress against deliverables

A total of six deliverables were identified in the communication and advocacy strategy for the period of 2010 to 2012. The table below summarises progress against these deliverables so far:

Table 5

Deliverable	Progress
Baseline awareness and perception survey of TDR conducted	Activity halted due to budget constraints and was therefore not carried out.
Increased and focused communications to potential new funders/donors and partners	<p>A number of parallel strategies have been put in place including:</p> <ul style="list-style-type: none"> ■ Developed packages on different products targeting fund raising ■ Support to grant writing across TDR priority areas ■ Increasing awareness of TDR to funders by including them on the e-news list, redesigning the news letter to be more advocacy focused (e.g. including short pieces with less technical detail) ■ Putting out the newsletter more frequently and extending the readership (now includes 14.000 names, includes all donors) ■ Producing fact sheets for targetted advocacy to donors e.g. dengue, TB, diagnostics ■ Developing talking points, hand outs, press releases ■ Conducting regular telephone conferences with WHO offices to increase awareness, support and advocacy.
Improved communication results to policy makers	<p>The key inputs for this are the global report and Tropika.net.</p> <p>The process of developing the global report has included country and regional level dialogue and consultation, and production of draft documents. None of the expected reports have been published. However, a number of publications in peer reviewed journals were produced by scientists who were involved in the process.</p> <p>Tropika.net was established in 2007, and had a growing readership (up to 8000 visitors per month) until end 2010. Due to lack of funding it is no</p>

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Deliverable	Progress
	longer updated and readership has now dropped by almost half. TropiKA.net is now in the process of being transitioned out of TDR to another partner.
Common messaging with co-sponsoring and other partner organisations	Key messages have been developed and agreed upon with the JCB, these are used in all publications TDR logo was revised and also approved, a TDR identity was created, with a tag line, and key messages developed
Pilot module for communication training of TDR supported scientists to target wider audiences, especially on policy making	A pilot module was produced by TDR with WHO communications in house. This activity was not continued further with the TDR training centers as had been planned, due to budget cuts A training session was carried out with the leadership training groups to help them prepare communication plans.
Launching of the Global Report on Research on ID and related disease and thematic reports	Ten reports have been drafted by the groups and are in the process of being edited. Reports 1-3 will be published in the next six months. The global report is now expected to come out in February 2012 (see Section 9).

8.8.5 Perceived progress and utility

The interviews conducted by the review team underscore that overall TDR publications and communications (including TDR's own website) to the outside world are appreciated, seen as highly relevant, accurate, bring new insights and are generally considered to be of high quality. Both the print and electronic versions are valued and reportedly insightful and useful. Most interviewees would like to see TDR continue producing outputs of this kind.

Partner organisations also underscore that TDR has played a useful supportive role to their own communications, for example, the TDR scientist list has enabled (especially smaller) organisations to publish announcements (meetings, publications) and to gain visibility. The TDR's image library, built up over many years and which is free of charge, is reported to be a very useful resource for publications and work by other organisations. In addition, TDR's presence at exhibitions and events was also highlighted as a useful way of building networks and supporting other organisations, in addition to giving higher visibility to TDR.

A number of organisations have worked very closely with TDR in the organisation of international events. TDR reportedly collaborated very effectively, for example, with other partners in the preparation of the Bamako Ministerial summit. Partner organisations highlighted to the review team, the high level of professionalism and quality input by TDR into the organisation of such events, including in terms of developing key messages for various target groups, organising the programme and agenda, and putting out communications.

The views of Tropika.net vary. However, the majority of the DEC stakeholders who were contacted for this review, report that the resource is useful, easily accessible and provides them with a valued additional resource for their work, for staying updated and for participating in dialogue with others in their field.

The focus on integrating communication into research, which is one of the areas that TDR has explicitly worked on, appears to have begun to contribute to changing the way in which researchers look at their own work and are able to communicate about it. It has also ensured that communication is included in research processes at an early stage.

8.8.6 Weaknesses

In spite of this overall positive picture, a number of weaknesses emerge from the review:

- The absence of a base line means that it is difficult to make any assessment on how communications are affecting the perceptions of the key stakeholder groups. It also limits TDR's capacity in examining which strategies are more effective and have greater VFM. As a result, a number of interviewees questioned whether "all this communication is really necessary". The lack of a base line and tracking of communication impact is a major limitation at a time when TDR communications are particularly important, given the changing context and the continued need to mobilise funding and high level support for TDR.
- There has been insufficient focus and progress overall in bringing research evidence into policy and practice. Whilst TDR do not have a responsibility for implementation, they do have the remit to communicate research findings to departments in WHO. There is a dominant perception that the approach to doing so has not been sufficiently systematic and has also suffered from the fact that there is no specific person in charge of this area. The delays in the publication of the scientific and thematic reports (see below) and of the overall global research report have contributed substantially to the lack of progress in this area.
- Interviews with key informants highlight that communication is still not sufficiently aligned with advocacy fund raising. Although progress has been made in terms of focused communications to funding agencies, there is insufficient integration of communication and advocacy around resource mobilisation.
- While overall, interviewees appeared well informed about TDR's mission and activities, there is considerable misunderstanding and skepticism about the new stewardship and empowerment roles of TDR among many of the partners.
- The substantial and repeated delays in publishing the global research report and related scientific and thematic reports have raised considerable and persistent concern among stakeholders that the reports will be outdated and of very limited use by the time they are published. Given the considerable expense involved, this is a major area of concern. As this activity falls under stewardship, this will be discussed in more detail in that section of the report.
- The work around TropIKA.net has been mainly carried out within the stewardship team with little coordination with the communication section. The overall perception is that this huge undertaking was considerably underestimated. The fact that it was developed as a stand-alone activity with a distinct identity and with little integration with TDR's own communication activity represented a lost opportunity to use this tool also for advocacy for TDR. In addition, it has also reduced the level of ownership of the platform itself. Tropika.net is now reportedly being transitioned out (further details discussed in the stewardship section of this report) although the fact that its usage has declined considerably and that funding still needs to be mobilised to sustain the platform are both cause for considerable concern.
- Interviews highlighted that there are still issues around the relationship with other partners, in particular many of the Public Private Partnerships (PPPs) that have emerged in the past ten years, a considerable number of which are based in Geneva at close proximity to TDR. Some of these issues appear to pre-date the current strategy or are a reflection of poor relationships in the prior period and are aggravated by the fact that TDR reportedly puts itself in the position of competitor for funds. While such issues cannot be solved through more effective communications alone, these do underscore the need for TDR to review how it interacts with PPPs.

8.8.7 Recommendations

- In the current climate TDR cannot afford to lose visibility. The JCB should ensure that there is an appropriate budget for priority areas of communication and that this is targeted at addressing those areas that are at present most important for the continued functioning and future of the partnership including maintaining confidence in the organisation.
- Insufficient resources and priority have been placed on advocacy. Additional skills/human resources need to be identified within TDR to ensure that this area is covered adequately, and a closer integration of the communication and advocacy/fund raising functions within TDR needs to be sought.
- In the current resource restricted environment, particular attention (and corresponding resources) should be paid to monitoring the impact of priority communication efforts.
- TDR's current focus on stewardship and empowerment remains poorly understood. Specific communication and advocacy efforts should focus on addressing this.
- TDR needs to continue to prioritise working with other partners, rather than in competition with them.

9. Location of TDR

Whilst the future location of TDR was not an explicit part of the remit of the review team, it was inevitable that views were expressed by a number of informants. Whilst recognising the very high staff costs of location in Geneva and acknowledging the need to reduce costs, almost every person spoken to expressed reservations on the proposal to dislocate from WHO and Geneva. In summary, the points made were as follow:-

“Giving TDR back to Africa when it is having these issues is like giving a poisoned present”.

- Moving out of the main WHO building had already been shown to reduce the collaboration needed to ensure implementation and a further move would damage this even more
- Geneva was seen as a neutral location acceptable to all countries whereas location in a remote location could be seen to endanger impartiality.(i.e. an African based organisation could be perceived as favouring African projects over Asian)
- Working in partnership with both WHO focal areas (departments, other special programmes and hosted global partnerships) and with other partners based in Geneva was essential for collaboration and for avoiding duplication.
- The convening function of TDR was most easily and efficiently delivered in a location where many stakeholders had other reasons to visit and thus could share costs
- There were opportunities in Geneva to share support functions (planning/ communications etc) with other special programmes or similar
- Recruitment and retention was likely to be better in Geneva (this point was made less strongly)
- If a move was made to another country, it was felt that a sub Saharan Africa disease endemic country would be more appropriate
- Any country chosen needed to provide peer stimulus and relationships, preferably through a top rated research institution
- Any country chosen should have an international, trans continental airline hub

It should be noted that the Alliance for Health Systems Research also considered relocating (circa 2005) in order to strengthen country ownership and implementation and, after an extensive consultation, made the decision, based on similar arguments, to remain in Geneva.

“TDR has suffered from its geographic isolation (at CASAI Center) which was costly and resulted in reduced contact with the control programmes housed in the HQ building” Collaborating partner

9.1 Observations and Recommendations

At the time of writing the report, it seemed likely that TDR would vacate its current accommodation and relocate on the main WHO campus. The review team strongly supported this proposal and felt that every effort should be made to maximise synergy with departments and programmes within WHO.

10. Stewardship

10.1 Background

The fourth external review identified increasing fragmentation of research in a fast growing environment with more funding and players as a key concern. It also highlighted the expectation from partners that “*TDR would use its scientific and institutional legitimacy to facilitate coordination and governance of research as a public good ... (which is seen) as a crucial role that no other institution at present could legitimately fulfil*”. This recommendation resulted in the creation of stewardship as a specific function and business line in TDR’s strategy, with the overall objective of promoting knowledge management, needs assessment, priority setting and progress analysis and providing a neutral platform for stakeholders to discuss and harmonise their activities with DEC playing a pivotal role in agenda setting. A number of specific objectives were identified, as follows:

- Constitute a global platform on health research needs, opportunities and priorities for infectious diseases of poverty
- Put in place a forum for identification of priority needs and research gaps through stakeholder consultation and enhance the relevance of ID research priorities and control needs
- Provide a neutral platform for discussion of activities, for reaching consensus and for collective efficiency and advocacy for ID with active involvement of the DEC
- Advocate for support of health research and effective use of results in the control of IDP at international policy level
- Foster research networks and kick start innovative research initiatives

In order to achieve these objectives, the focus of the stewardship area in the period 2008-11 has been on bringing together a Think Tank of global experts on NTD to formulate recommendations on priority areas for research and to influence policy making. The Think Tank has involved over 130 experts who have worked in ten specific diseases or thematically focused groups on these issues. The process has involved meetings of the ten groups, as well as broad regional and global consultations to draw from the inputs of a wider group of stakeholders. The process of dialogue and discussion is expected to produce periodic, overall and disease specific/ thematic reports which are evidence based and which can be used as a reference, particularly for decision makers to inform agenda setting and resource allocation. Initially, the expectation was that the global report would be published biannually with annual thematic and disease reports. This has now been revised to updates of the global report every four years and supplemented by periodic thematic and disease reports.

A second major area of work has been the establishment of TropiKA.net. This is a global knowledge management platform for IDP which is targeted at: promoting equitable access to research information; sharing and disseminating research information; and pursuing priority research needs and gaps. The management of the platform has included a number of tools for facilitating collaboration and dialogue between stakeholders involved in research on IDP, including the establishment of knowledge hubs, of stakeholder ‘commons’ (aimed at consensus building and agenda setting among stakeholders), communities of practice (collaborative workspaces); infographics (interactive maps on the distribution of IDP); and e-learning platform (for knowledge transfer through media sharing); and journal clubs set up by eminent institutions. The mechanism includes inputs from a dedicated team of editors, writers and webmasters based in different locations, as well as an open access peer reviewed journal focusing on publishing scoping reviews on IDP.

10.2 Management of the stewardship function

The original proposed management structure of the stewardship function comprised five professional staff in 2008, with the intention this would grow to six staff for the remaining period of the strategy. The unit was to be supported by four support staff.

After the restructuring, the staff was reduced to three professional staff and one support staff. The restructuring/re-profiling process has resulted in staff being re-assigned to stewardship from research/scientific areas. It is generally felt that this restructuring/re-profiling has not produced the best matches, in particular because staff may have been assigned to an area where neither the institution, nor they themselves, have sufficient prior expertise or understanding. The perception among outside stakeholders is also that TDR does not appear to have the expertise in house to take the stewardship function forward adequately and this is crucial given the importance of the agenda.

The work around stewardship is guided by a Strategic Advisory Committee (SAC) for stewardship which was constituted in 2008. The role of the SAC is to provide direction and guidance in implementing the objectives of stewardship. At the time of this report, the SAC had met twice a year (four meetings in all in 2009 and 2010). A fifth SAC meeting planned for January 2011 was cancelled because of the financial situation in TDR. A number of the members of the SAC have also participated in consultation meetings in their region and in Global Report Production workshops which are further discussed below.

TDR staff working on stewardship report that the SAC has been of value in providing direction and guidance in implementing the objectives of stewardship. This contribution is considered particularly important given that stewardship was a new area for TDR. However SAC members stated that much of their advice on approach and process were not taken on board, and found the process of providing support to this area hugely frustrating. Concerns were expressed in particular in relation to the Global Report about the size of the task and the manner in which it was being rolled out, but this did not result in significant changes in approach.

More recently, and following the merging of the stewardship and empowerment areas functions within TDR, the chair of the SAC for empowerment has also joined the stewardship SAC. TDR staff considers this a useful move as it has provided internal coherence. Externally however, the merging of the stewardship and empowerment areas has been perceived as *“empowerment being subsumed into stewardship”*. This development, together with the cancellation/postponing of activities is widely seen as an indication that TDR is reducing its focus on an area that is considered very important, particularly given its traditionally strong, and much appreciated, role in capacity building (See Section 11).

10.3 Funding for Stewardship

Over 80% of the funding from stewardship comes out of undesignated funding. The remaining funds come from a grant that is provided by the EC. As is the case for other areas, (such as empowerment) the current financial difficulties have had an adverse impact on funding for stewardship. This has contributed to delays in implementation, and has affected the relations with some of the partners as initiatives have been postponed or ended. The members of the Global Think Tank for the Global Research Report on IDP in particular have been anxious to hear how the work will be continued and lack of communication early in 2011 has left a damaging legacy.

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10.4 Progress with respect to expected end products

The business plan for this BL established a number of end products. The table below summarises the overall progress so far towards these:

Table 6

Deliverable	Progress
Establishment of on-line global knowledge platform for IDP (launch 06/2007)	<ul style="list-style-type: none"> ■ TropiKA.net was established in November 2007. The number of users reached 5000 per month after the first year and saw a steady increase in users until late 2010 when the number of users averaged over 8000 per month. ■ Due to funding constraints the platform was only sporadically updated in 2011 and usage has dropped by half between 2010 and 2011. ■ As part of the restructuring following the financial difficulties, arrangements are now being made to move TropiKA.net out of TDR, and partners/arrangements are being sought to take over the funding and overall management. The possible engagement of outside partners was under discussion at the time this report was being prepared.
Disease or thematic reference groups of global experts in diseases or cross-disease areas established and continuously reviewing needs and opportunities, and high impact annual updates published	<ul style="list-style-type: none"> ■ Ten disease and/or thematic reference groups forming the Global Think Tank on IDP has been put together. ■ The work of these groups is being hosted by eleven WHO Regional or Country offices. ■ The disease/thematic groups have produced internal reports reflecting the research landscape and the agreed upon top level priorities. However these have not yet been published, and neither have any annual updates.
Up to date published reports on research opportunities, needs and priorities and research achievements for individual ID or cross-disease issues published and promoting DEC research	<ul style="list-style-type: none"> ■ No published reports to date. As noted the ten reference groups have produced reports on the research landscape and top level priorities for research. The plan is to transform these reports into volumes of the WHO Technical Report Series (TRS). The reports are currently going through an editorial process, the first three reports are expected to be published by April 2012.
Comprehensive analysis conducted of regional or global research needs, science opportunities and challenges to health systems	<ul style="list-style-type: none"> ■ This analysis was conducted through the work of the disease and thematic groups and the Global Think Tank. Seven national and regional stakeholders' were organised in Africa, Asia and Latin America. The four regional consultations were organised in EMRO, SEARO, WPRO and AMRO/PAHO around specific themes: zoonotic and marginalised ID; ID of Poverty in SEA countries; innovation and technology for ID of poverty; and dengue and other emerging viral diseases.
Biennial report on ID research: priority needs, gaps and global progress (first publication by	<ul style="list-style-type: none"> ■ Publication has been delayed. Twelve international leaders in research and public health have co-authored the report which is in draft form. In January 2011, the Global Report was discussed

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Deliverable	Progress
12/2009)	with stakeholders in Shanghai. The Report is currently being reviewed for publication. Publication delayed. Now expected in February 2012.
Collective advocacy for new opportunities in ID research, with evidence of activities initiated or enhanced, and with DEC institutions playing a pivotal role	<ul style="list-style-type: none"> A limited amount of advocacy has taken place through the meetings and consultations related to the Global Report, and side publications in peer reviewed journals. Delays in the publication of the reports have meant that more systematic advocacy has been limited.

10.5 Financial Analysis of Stewardship function (\$m)

Table 7

	2008/09	2010/11
	\$m	\$m
Personnel Costs	2.6	2.9
Coordination	0.4	0.4
Knowledge management	1.0	1.0
Priority needs	0.8	1.8
Consensus Building	0.3	0.1
Symposium on Health Systems Research		2.0
Networks and initiatives	0.1	0.1
Other	0.1	
Total	5.3	8.3

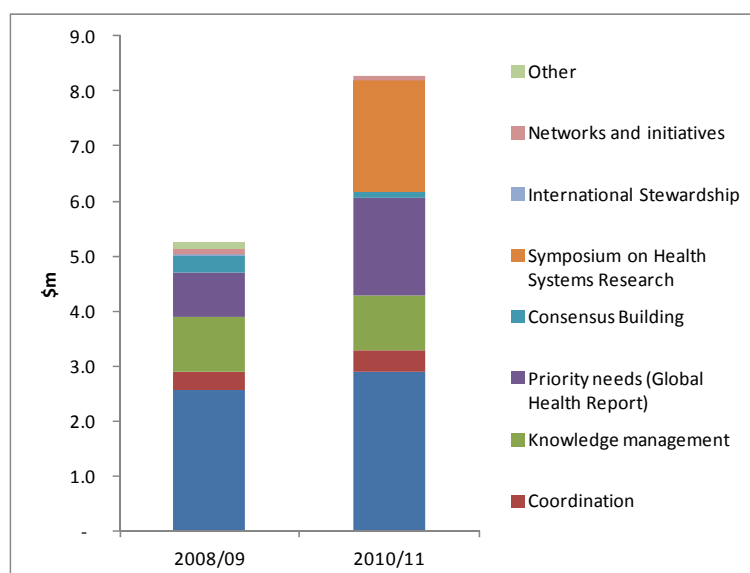
Total expenditure for Stewardship in the period 2008-2011 is estimated at \$13.6m. The Symposium on Health Systems was wholly funded through a designated grant of \$2.0m in 2010/11. The expenditure on activities for knowledge management (development of the TropIKA platform) is estimated at \$2.0m for 2008-2011. The majority of the remaining expenditure in 2008-11 (\$9.6m) and budget for 2012/13 is associated with the development of the global think-tank and production of the Global Health report and is largely financed from undesignated funding.

Information from informants and study of documentation raise questions regarding the level of expenditure in Stewardship, and whether these represent value for money, particularly with regards to the production of the Global Health Report.

The Report's effectiveness may be compromised by the concerns raised over its timeliness/relevance, due to the long production process which has been compounded by delays associated with the financial situation, and lack of clear plans to get the outputs of the report into DEC or TDR agendas. During interviews, the cost efficiency of producing the Global Health report has been contrasted with the relatively small budget required for scientific working group reports, which are much less broad in scope but are reported to arguably have potentially greater relevance and impact in driving disease-specific agendas.

Stewardship is labour intensive and personnel costs represent 39% of total costs. Opportunities to improve efficiency should be explored.

Figure 6 Stewardship Expenditure 2008 – 2011



10.6 Observations about stewardship

While the fourth external review reported that stakeholders felt that TDR was uniquely placed to play an impartial and facilitating role in stewarding, the overall message to the Review Team from persons interviewed did not confirm this. For most of the partners, TDR is not perceived as a neutral partner; in fact, for many partners interviewed, TDR has a specific agenda related to implementing its own priority programmes and to raising funds, which puts it in a situation of competition vis-a-vis its partners, and has biased the work in a particular direction.

In addition, it was very clear to the reviewers that the majority of the outside stakeholders do not identify with the term stewardship, which as is the case for empowerment, is not clearly understood and felt to be patronising.

During the early part of 2011, there was considerable concern expressed by the scientists involved in leading the topic groups who did not feel that they were being adequately communicated with in regard to rationalisation and the financial situation. This has resulted in a degree of ongoing disenchantment.

There are also considerable doubts and, in some case unhappiness, about the manner in which the work process in the stewardship function is being carried forward. As one interviewee noted there is “too much convening and too little learning”. Overall, interviewees underscored that work in this area has not been dynamic and quick enough.

Questions have been raised (mostly externally but also internally) – around the high costs associated with the global and regional meetings which it was felt, were difficult to justify. It is widely felt that the process has been very heavy from a transactional perspective. There is also a lack of clarity among participants in

the process on who the final end users of the reports are and how these will be specifically targeted to ensure that the results influence policy making.

Finally, but not less importantly, there are significant concerns and frustration among participants in the disease and thematic groups about the substantial delays experienced so far. A particular concern in some of the areas is that the work is quickly becoming outdated. TDR staff themselves do not share this view; given the more overarching nature of the reports, the perception is that the delays are not serious. The concerns of outside stakeholders are further amplified by the fact that, as a result of the restructuring of TDR, the future of the Think Tank is unclear.

10.7 TropiKA

TropiKA.net was set up as a separate undertaking within TDR which, while based in the stewardship function, has drawn relatively little on the communication expertise/section of TDR. The fact that it was set up with a separate brand name is seen internally and externally as a lost opportunity to do some much needed advocacy for TDR and has reduced the level of ownership of the initiative internally. Additional concerns relate to the complexity of setting up such a resource, and the level of expense and management involved, both of which were underestimated by TDR. The initiative did not benefit from a prior analysis of sustainability and/or appetite among partners for taking over this resource from TDR.

10.8 Observations on Stewardship

Overall the results in the area of stewardship are found by the review team to be disappointing so far given the apparent potential. Three indicators on stewardship were identified for progress in TDRs own monitoring framework. No progress has been registered on two of these, and the third one has only been partially achieved. With over a year of delay and with further delays still expected, it is understandable that these should be serious concerns.

10.9 Strengths

- Stewardship continues to be seen as an important function within the research and policy community, it therefore potentially addresses an important need and still has relevance.
- The process of producing the Global Report has involved a strong degree of involvement and leadership of DEC
- The establishment of thematic reference groups is seen as an important development, highlights topics and issues that are fundamental to ID prevention
- The global research report on IDP of poverty is felt by interviewees to have potential to make a significant contribution, especially in a changing context where non-communicable diseases are becoming more important.
- TropiKA.net is seen by the majority of DEC as an important and useful resource which fills a gap in terms of access to and participation in dialogue around IDP.

10.10 Weaknesses

- As noted above, the term stewardship is not well understood by external partners and also not understood internally. Within TDR, human resources for the stewardship function were allocated in an arbitrary manner when Stewardship was created, which represents a particular problem as this is a new area to TDR.

- TDR has not established itself as a neutral partner. It is perceived as having vested interests as a competitor for funds, and does not have the legitimacy which the fourth review had identified. The agenda around stewardship is widely perceived as not being neutral, but rather as being driven by TDR interest in advancing areas that it finds important. This perception has been furthered under the current financial constraints.
- The focus of stewardship seems to have been more on convening rather than learning, and the areas of focus are ones that other stakeholders don't necessarily easily align with.
- In developing the Global Report, there has been an underestimation of the size of the task, and insufficient clarity up front on the processes. Successive changes in scheduling and delays have reduced confidence by the participants in the process and its outcomes. There has been insufficient emphasis on learning from other initiatives of this kind.
- There is insufficient clarity among contributors on the key target groups for the work and on the processes for influencing policy beyond the production of the actual report. There are also concerns about how this report links in with the overall report on research which WHO is preparing for the WHA.
- There have been very substantial delays in the process leading up to the publication of the Global Report. It is not clear why these delays have been so substantial although there is a perception that the initial draft was not of sufficiently high quality.
- The VFM of stewardship is questionable given significant sums spent and the potential loss of relevance due to delays. In addition, this areas draws heavily on undesignated funding. Questions need to be raised as to why this process is so much more expensive than the previous scientific working groups which were less costly (approximately \$100,000 for disease specific publications), were produced in a timely fashion and successfully set the agenda for each disease.
- While TropiKA.net appears to be a useful resource to many users, it was insufficiently advertised (for example by the regional WHO offices) and since the beginning of 2011 is no longer being updated because of funding difficulties. With respect to this area also, there has been a substantial underestimation and lack of advance planning on the size of the undertaking by TDR.

10.11 Recommendations

- Priority needs to be given to expediting the process of publication of the reports from the global consultation process so as to avoid further loss of credibility by TDR and ensure that this part of the process is completed.
- There needs to be a methodology developed to measure the effectiveness and impact of these reports given the significant cost of production
- Clear decisions need to be made, in light of the current resource constraints by TDR, as to the focus and process for stewardship beyond the work that has been done to date, in particular the extent to which TDR will be able to carry forward the planned periodic revision of the Global Report and disease specific and thematic reports.
- The post-publication process and the communication and dissemination strategies for these products need to be carefully reviewed and reconsidered in light of the available financial and human resources by TDR. The focus should be on identifying areas and strategies of potential high impact. Priority should also be given to identifying partners that can help TDR in taking the processes and products forward.
- Decisions also need to be taken relatively quickly on the future of the Global Think Tank which has involved considerable contribution and good will from a large and eminent group of persons who are expecting to hear how TDR expects to continue this work. Consideration should be given to reorganising the Think Tank and to using a new operating mode to reduce costs.
- Beyond the global report process a major effort in refocusing and re-strategising the Stewardship function should be made, in order to ensure that the goals are matched with clear strategies that are

achievable in an efficient manner. This may include a rebranding of the function to address the dislike that partners appear to have of the term stewardship.

- The process of identifying a replacement for the outgoing head of stewardship will most likely be an internal one. It is critical, given the importance of this area for TDR, that the selection be carefully focused on identifying an internal candidate with the strict proviso that they have the expertise in this area and the capacity to develop the necessary outreach to partners

11. Empowerment

The empowerment function has the following objectives:

- To support the development of health research leadership in DEC's at all levels;
- To strengthen the capacity of institutions in DEC's to enhance the quality and relevance of health research outputs;
- To strengthen the capacity of national research frameworks in DEC's to provide an enabling environment for researchers on the infectious diseases of poverty;
- To leverage the role of researchers, institutions and governments to gain a stronger position in health research globally.

11.1 Management of the empowerment function

The original proposed management structure of TDR empowerment function appears relatively resource heavy given the reduction in funding and thus workload. Under the 2008 forward plan it was envisaged that TDR's empowerment function would be organised into four teams:

- Research Team
- Training Team
- Network and Partnerships Team
- Leverage Team

Each team would have oversight by a technical committee. A Strategic Advisory Committee (SAC would oversee the range of empowerment activities across the Business Line). It is interesting to note however that the chair of the previous Empowerment SAC was not originally included in the new joint committee. With the rationalisation, staffing now consists of six persons and the SAC has not been convened nor the oversight committees. Whilst this is understandable, it means that there is little independent input or oversight to the unit.

11.2 Funding for Empowerment/ Capacity building

In 2008-09 the total expenditure on empowerment amounted to \$5.89m but this reduced to \$3.39m in 2010-11 with designated funding dropping from \$1.15m to \$1.11m and undesignated funding showing a reduction from \$4.74m to \$2.28m. Designated funding has largely been used for individual capacity building and support of research institutions.

The forced reduction in expenditure has resulted in some loss of confidence in individuals and partner institutions particularly when agreed initiatives have been delayed or not taken forward.

Empowerment appears to support a wide range of small initiatives and it is difficult to see how these all integrate together to achieve the strategic objectives.

11.3 The Name of the Programme

The term empowerment has been used since 2008 and encompasses activities previously known as capacity building. The term empowerment appears to be widely disliked, particularly by DEC partners, many of whom see it as patronising and paternalistic.

"It is not up to TDR to give us power. They need to work with us, not do things to us"

More than one interviewee mentioned that empowerment was a term used, often in civil society settings, when working with people who were perceived as weak. They felt it was inappropriate when working with fellow professionals. Whilst the intention behind the name change was laudable, it is suggested that consideration be given to reverting to a name which is less controversial and better understood.

11.4 Institutional Strengthening

Over time TDR has changed its focus in capacity building with a greater emphasis on the institution rather than purely on the individual. This focuses not just on internal processes, systems and infrastructure, but much more on how the institution as a whole can work strategically in their national and regional context.

TDR has continued to strengthen infrastructure through research equipment etc but this has been less of a priority. Much of the work undertaken to strengthen institutions has focussed on leadership with a view to increasing understanding of the national and international context for research and giving institutional leaders the competences and confidence to advocate for research and work with government and stakeholders to ensure that research findings are incorporated into policy.

TDR has also aimed to strengthen certain functions and processes in institutions and much of this is done as a bi-product of undertaking research. Thus, for example, TDR supported appropriate project development aiming at ethical approval.

11.4.1 Institutional strengthening grants.

Two specific institutional strengthening grants have been made with CIAM - Public Health Research and Development Centre in the Gambia being supported to train health workers in malaria diagnosis in the context of a project seeking to improve the accuracy of malaria diagnosis and improved management by village health workers. The University of Yaoundé in Cameroon is receiving TDR support to strengthen capacity in Good Clinical Laboratory Practices (GCLP) and data management. It is understood that progress on these two initiatives is slower than anticipated.

11.4.2 Working to agreed Standards

It is understood that, whilst TDR uses international standards for research laboratories and standards set for clinical trial sites, there is currently no agreement on agreed institutional standards which should be achieved through capacity building for a research institution overall. This is increasingly a trend internationally for institutions in other fields.

Organisational standards are agreed and institutions can be assessed against these. In some cases adherence to these standards is necessary for registration or accreditation but they are also useful in demonstrating to potential funders that the institution is well run.

Given the work undertaken by ESSENCE (see 11.5) it would seem a logical extension (and coherent with the normative role of WHO) to consider using TDRs convening function to develop such standards and develop an organisational audit tool which could be used for both self assessment and for external QA. Co-ordination with the other special programmes in WHO would seem logical, in so far as they too have a capacity building function with research institutions.

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11.4.3 Leadership Training Grants

This has been a new initiative with eleven people initially enrolled in 7 African and 2 South-Eastern countries. The emphasis is on institutional development alongside individual training potential. There has been one person drop out due to unfulfilled expectations. The programme both provides grants but also arranges mentorship. Preference is given to applicants from least developed countries and to women.

Although participants have been followed up on a six monthly basis and have shared their work, there is a recognition that this does not provide enough information to assess whether the programme has been successful in its aims or indeed provided value for money.

11.4.4 Network Development

TDR recognises the value of institutions in DEC countries networking to increase their collective voice, learn lessons and work collaboratively. Work in this field includes:-

11.4.5 ISHReCA

Since 2009 with support from the Wellcome Trust TDR supported the Initiative to Strengthen Health Research Capacity in Africa (ISHReCA). This was intended to provide a platform for African health researchers to discuss needs and models to build sustainable capacity for health research in Africa. TDR was initially hosting and supporting the ISHReCA secretariat. The manager was financially supported by TDR through a fellowship and this continues until the end of this year. Hosting has transferred to an institution in Cameroon (CIRCB in Yaoundé). There is an annual workplan overseen by a Steering Committee comprising various research leaders in various regions of Africa. It is difficult to quantify how successful the transfer process has been but the website has not been updated since mid 2010 which is concerning given this is the point of engagement for many participants.

11.5 ESSENCE

ESSENCE (Enhancing Support for Strengthening the Effectiveness of National Capacity Efforts) is an initiative which is designed to bring together funders for harmonisation and alignment with countries and which is hosted at TDR. Essence has been responsible for the design of the Planning, Monitoring and Evaluation Framework for Capacity Strengthening in Health Research. This provides a comprehensive matrix which organisations can use to assess the outcomes and outputs of their capacity building work. It builds on the work undertaken by TDR on its own performance assessment framework. It is a useful concept, elegantly executed. However, it requires monitoring to establish to what extent this framework is actually used by organisations to guide the assessment of their capacity building work.

ESSENCE has also undertaken other convening activities including organising a panel at the INDEPTH Scientific Conference (Mozambique 2011) to look at data sharing. ESSENCE has also developed a draft inventory of African research funding agencies. This is part of an initiative to agree how ESSENCE members will interface with African research councils in 2012.

11.6 Regional Training Centres

These have been developed in four countries (Columbia, Philippines, Kazakhstan, Indonesia) with TDR providing seed funding and helping agree programmes. TDR has seen itself as the catalyst for these developments but not necessarily a long term funder. It has not been possible to develop an African centre

and this is unfortunate given the needs of sub Saharan DEC countries, although there are aspirations to create this in 2012. Such a centre would promote collaboration, exchange of good practice and would support the development of advocacy alliances involving institutions across the region.

A number of courses have been delivered in the last two years including courses in Good Clinical Practice, EPPE and scientific writing. These centres are envisaged as becoming hubs for capacity building. It is worth noting however that promotional material places a heavy emphasis on short courses. Whilst short courses are proven as being useful for knowledge transfer and networking they are less effective for skills development particularly in the fields of management and leadership.

It will be import to assess over time whether the investment in these centres has led to long term sustainability.

11.7 Individual Support

There was a unanimous opinion amongst partners, particularly those in DEC's, that individual capacity building has been extremely important and successful for many years. A large numbers of researchers in DEC's have, in the past been helped to promote their careers by TDR. In the recent past, individuals have been supported through a number of different mechanisms and this has been an attempt by TDR to offer a menu of development opportunities.

"I am very grateful because of the experience which I got through TDR, although the training itself could be more innovative". Past recipient

11.7.1 Research Training Grants

Over many years literally hundreds of scientists have been supported to obtain appropriate qualifications. This year due to financial constraints no new grants have been offered. There have been 15 students in training (AFRO (Ethiopia, Kenya, Malawi, Mali and Uganda), AMRO (Ecuador), EMRO (Afghanistan), SEARO (Nepal) and WPRO (Cambodia) and all are coming to the end of their training periods.

In the past, many students studied in northern institutions but there has been a recent move to support training in national organisations. This is perceived as lower cost but also less likely to result in long term migration. This theory is sound only if adequate local capacity exists with the infrastructure to support quality training and development.

This is recognised and the individual training grants are being reduced in number and replaced by Leadership Training Grants which also support the institution as well as the individual.

11.7.2 Career Development Fellowships

These support scientists early in their careers and are funded by the Bill and Melinda Gates Foundation. Scientists have the opportunity to work in pharmaceutical companies for one year with the aim of bringing back the learning to their home institution. In the last two years, twenty fellows have been trained and fourteen are currently attached to laboratories.

An exciting initiative funded through TDR's Gates grant is being explored in conjunction with Oxford University to support ongoing Continuing Professional Development (CPD) through participation in a database and computerised "career management" programme. So far five students have piloted this with

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good feedback. This initiative will provide a double benefit with the participants being able to demonstrate their growing competence as an ongoing process and will also be able to provide non attributable information to track cohorts who have benefitted from personal development through TDR and thus demonstrate outcomes and impact.

It should be noted that other organizations such as Burroughs Wellcome Fund (US) have developed a series of programmes and publications on laboratory management and managing early career years that could contribute to this work.

11.7.3 CDF through the Think Tank on infectious diseases of poverty.

This initiative provides opportunity for DEC scientists to acquire new knowledge and skills not readily taught in academic institutions during a period of attachment to TDR disease or thematic reference groups. Currently there are ten fellowships which are due to finish this year. The objectives are to: 1) Learn through a supporting role in the collection of research evidence, prioritisation and preparation of reference report, 2) Develop skills in specialised disciplines that are addressed by the think tank, and 3) Strengthen knowledge on identified research areas in their home institutions and regions.

It was not possible to undertake an assessment of this initiative in the time available but much of its value will lie with the willingness of members of the reference groups to engage with participants and provide mentoring and for the fellows to have opportunity to use their newly gained competences on return to their home country.

11.7.4 Training of Clinical Trials Monitors

TDR has undertaken a number of courses to train clinical trials monitors. Although the course is short, costs have been high as many courses were held in Thailand rather than in Africa where the majority of monitoring are likely to be required. There does not appear to be formal ongoing assessment of the quality of monitors although informally it is estimated by TDR staff that only about 50% of the monitors on the current register are deemed fully competent. This raises issues about value for money if lack of follow up results in such a high wastage rate.

11.7.5 Post doctoral re-entry grants

TDR has recognised the difficulty for new scientists in obtaining grants for small research projects and has supported these to good effect. Grants tend to be in the region of \$10-25,000 and enable scientists to gain a track record. This appears to have been very successful based on individual feedback and anecdotal evidence although it is difficult to get definitive overall information as no long-term prospective tracking database exists. It is important that grants are available to scientists regardless of whether the re-entry is from abroad or in country training.

"I am now a scientist in my own right and am able to mobilise funding on a competitive basis from major sources, without needing TDR anymore".

11.8 Other players engaged in Empowerment Activities

In the last three years, five European Foundations have joined forces to create the European Foundation Initiative on Neglected Tropical Diseases (EFINTD) which provides support to Junior and Senior Post Doctoral Fellows. The Foundations involved in a Pan European collaboration are Nuffield (UK), Cariplo

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(Milan, Italy), Merieux (France) Gulbenkian (Portugal) and Volkswagen (Germany). Funding is for 3 years with a possibility of extension and provides for local PhD training, travel to a European mentor's laboratory and attendance at meetings; there is an opportunity to submit an application for renewal. It is reported that this has had considerable success despite being a highly competitive process. The demand in Africa alone is significant as for all three rounds to date there have been between 70 and 100 pre-proposals. This would appear to offer an alternative source of funding to TDR.

Likewise Wellcome is perceived as increasingly offering support with relatively applicant friendly processes. The BMGF has funded capacity building extensively through it's former Gates Malaria Partnership and the US NIH Fogarty international Centre has funded trainees through its D43 training grant mechanism.

One comment received from grant recipients has been the problems experienced due to excessive bureaucracy and time delays. There is a risk that TDR has increasingly stopped being the single source of preference in this field.

Many of these organisations are offering training in Europe or the US whilst TDR has offered local and regional training and institutional capacity building but for individual researchers the opportunity to access external training may be attractive

"I am grateful that TDR supported (my institution) but the process took too long" DEC scientist

11.9 Financial Analysis (\$m)

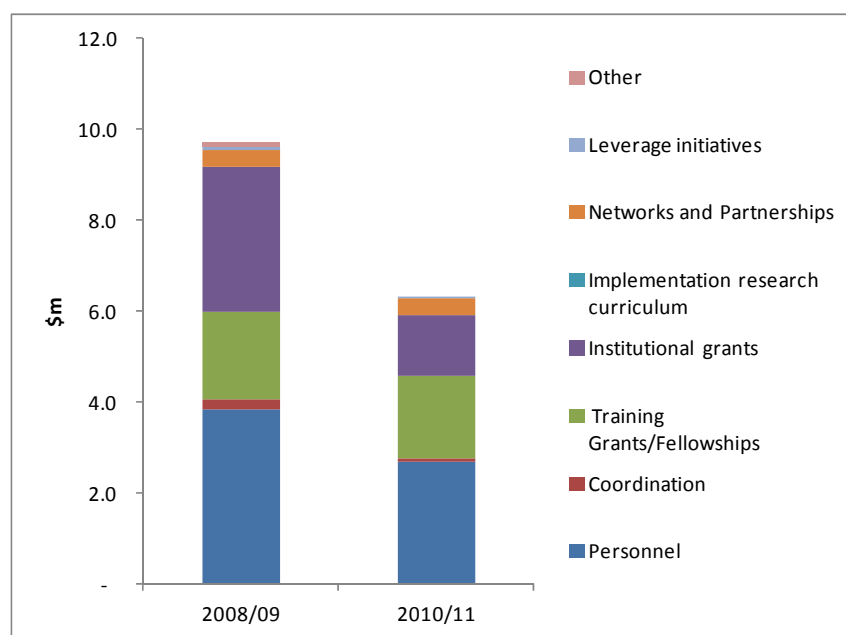
Table 8

	2008/09	2010/11
	\$m	\$m
Personnel	3.8	2.7
Coordination	0.2	0.1
Training Grants/Fellowships	1.9	1.8
Institutional grants	3.2	1.3
Networks and Partnerships	0.4	0.4
Leverage initiatives	0.1	
Other	0.1	
	9.7	6.3

Total expenditure on Empowerment is estimated at \$16.0m for the period 2008-2011. Overall, the contribution of TDR's institutional and individual training grants and fellowships to capacity building in DEC's represent 51% of total expenditure 2008-2011. Due to financial constraints, there has been an estimated 59% reduction in institutional grants in 2010/11, which is inevitably detrimental to achievements in capacity building and appears contrary to the strategy to increase institutional strengthening and reduce individual.

Personnel costs are relatively high as a percentage (41%) of overall costs 2008-2011, which raises questions as to whether efficiency could be improved.

Figure 7 Empowerment Expenditure 2008-2011



11.10 Overall observations and recommendations on empowerment/ capacity building

The review team recommends that TDR builds on its comparative advantage and track record and continues to focus on capacity building both for institutions and individuals. Due to the loss of confidence caused by curtailment on financial grounds, it will be essential to agree a realistic programme of support and ensure delivery.

This is perceived to have been an area where TDR has had significant impact and many of the current cohort of senior scientists working in diseases of poverty have benefitted in the past. There is however no systematic methodology for following up recipients so it is difficult to measure effectiveness in terms of career progression/ grants obtained/ papers written/ continued employment in national institutions etc. The system established by at Oxford University (see section 11.7.2) would appear to have the potential for wider application and might assist in tracking scientists who have received training grants. This is worth keeping under review.

Perhaps more importantly, it would support the development of a Competence Framework. These would identify the skills, knowledge, attitudes and behaviours required to undertake research (by level) and would provide the basis for design of all training and development in the future. This currently does not exist and it is difficult to understand how capacity building of individuals can be systematically undertaken unless there

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is clarity about what competences they need to demonstrate to do the job. This is international accepted practice in many professions and fields of practice.

TDR has focussed on the role of clinical trials monitors who oversee research in the field. Training and support has been provided and TDR maintains a relationship and uses them on a contractual basis for quality assurance. Many of the monitors are senior researchers in their field and there is the opportunity to use them both for external quality assurance but also for lesson learning across institutions. Interviews indicate that this may not be utilised to the full in this way and monitors are perceived more as external auditors than as developmental facilitators. This may be an opportunity which could be maximised.

11.11 Capacity Development

Since 2009 Business Lines 3 (Lead Discovery for infectious tropical diseases) and 4 (Innovation for product development in disease endemic countries) have been combined under a single team at the recommendation of the STAC. This workstream has been transferred under the Stewardship and Empowerment Section since early in 2011

The primary objective of BL3 is to help fill the “translational innovation gap” through an integrated north – south drug discovery network. Since 2005 TDR has been working a) identification of new drug leads through the coordination of north south network to ensure efficiency, maximise resources and chances for success; and b) building alliances and partnerships while promoting innovation in disease endemic countries (DECs) through training and capacity building.

The work of BL4 has focussed on the development of the African Network for Drugs and diagnostics Innovation (ANDI) as a regional innovation network with the aim of strengthening leadership, investment, ownership and capacity. Since 2008 TDR has been supporting the development of the African Network for Drug and Diagnostics Innovation (ANDI). ANDI promotes African-led product R&D innovation through the discovery, development and delivery of affordable new tools, including those based on traditional medicines. At the present time, the hosting of ANDI is being transferred to the United Nations Economic Commission for Africa (UNECA) in Addis Ababa, Ethiopia but it continues working with the Innovation Networks team at TDR. It is currently working to set up regional hubs in each of the African regions

TDR has supported the establishment of the governance framework for ANDI including the identification of the Board, STAC. ANDI has also supported the identification of Centres of Excellence (CoE) including calling for abstracts and projects. It is envisaged that thirty two centres will be awarded as ANDI CoEs.

This was due to take place at the fourth stakeholders meeting which was held during the period of the review and over five hundred participants were booked to attend with many from institutions in DECs. A very large number of papers, posters and oral presentations were planned but timing precluded any assessment of the event as part of the review.

TDR has also supported the establishment of the Asian Network for Drugs and Diagnostics Innovation which includes the China network, the India network and the ASEAN network . In each case one of the first tasks undertaken by these networks has been a mapping exercise. Following this it is envisaged that accessible databases will be established to capture information on results, projects, institutions and investigators. The second phase of the initiative will involve brokering relationships to support research and development activity within DECs.

At least one of the networks has already obtained local funding and it will be crucial that the networks work towards becoming self supporting.

11.12 Conclusions and Recommendations

There is a view amongst interviewees that the resources required to support these networks have been considerably underestimated. Whilst ANDI has attracted considerable support including funding from the EU, it will be necessary for TDR to agree how much ongoing input it will provide and over what period of time. Given the intentions to have like institutions worldwide, TDR will need to clarify its role for the future as a catalyst for establishment, a long term funder or a collaborating partner.

12. Research

12.1 The background to TDR research efforts

Neglected tropical diseases are generally recognised as a group of parasitic and bacterial infections which have impact on vulnerable and poor communities. The diseases have a common characteristic in that they have the potential to be chronic, disfiguring and stigmatising. Multiple NTDs may affect individuals simultaneously. However, control programmes have had considerable impact in the last twenty five years with the potential to control and even eliminate some of these diseases at low cost.

The environment for working in the field of neglected tropical diseases has changed significantly since TDR was set up in 1975. First and foremost there is now a range of drugs, drug combinations, tools and strategies. It is estimated that more than 50% of the 18 new drugs or drug combinations which have been registered since 1970 have been the result of TDR collaborations.

There are many more players in the field both focussing on all NTDs but also on individual diseases. In recent years, WHO set a global target to reduce helminth infections (2001) and this was followed by the introduction of MDG 11 which incorporated access to clean water and adequate sanitation which impacted on NTDs. The Global Control Programmes including GPELF, OCP and later APOC, the Schistosomiasis Control Initiative, started by the Gates Foundation and Imperial College and the Global Leprosy Programme have worked with pharmaceutical companies to implement large scale control programmes.

In 2008 there was a global recognition of the need to increase effort in the field of NTDs confirmed by leaders of the G8 countries. There was significant investment from the US, UK, Canada and Japan and the Bill and Melinda Gates Foundation. Pharmaceutical companies provided discounted and donated drugs. This meant that there a massive increase in resources for diseases in which TDR had a particular and core interest.

However, despite effective interventions being available, particularly for the seven most common diseases, there are still challenges due to the changing economic, environmental and social environment . Urbanisation, changes in agricultural practice, conflict, climate change, increased mobility and globalisation all have the potential to impact on NTDs. These diseases still have a major impact on morbidity and estimates suggest that up to 1.4 billion people are infected with one or more NTD with further 2 billion at risk. Furthermore a majority of funding for these diseases has been appropriately focused on implementation of control and elimination programmes but this has meant that there has not been a commensurate focus on research into better means of control.

TDRs initial focus was on eight tropical diseases: malaria, leprosy, schistosomiasis, leishmaniasis, onchocerciasis, lymphatic filariasis, chagas disease and human African trypanosomiasis (HAT). Much of this work focussed on supporting drug and diagnostic development and vector control but, in parallel, TDR was working on social research to translate new approaches into effective interventions. In addition TDR has, in the past, funded a considerable amount of vaccine related basic research and some comparative studies. This included basic immunology training.

The second external review of TDR in 1987 identified the need for more field and socio economic research and this subsequently was adopted as a priority with significant results. It also recommended TDR to address interactions between HIV infections and target diseases and this subsequently expanded to tuberculosis as well. TDR has also expanded to encompass dengue and health systems associated with NTDs.

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It would seem that initially there was clarity in the minds of both funders and those who applied to TDR on the focus of its work. Some of this clarity has been lost and there is general agreement that, whilst the majority of TDR's work is highly relevant there has been some encroachment into fields where TDR does not have comparative advantage and the main motivator has been income generation. This was recognised by senior staff interviewed as part of the review.

"The strategy appeared to be one of aligning TDR with the latest buzz words and the new and upcoming topics." STAC member

12.2 The disease focus for NTD research

Having started with eight diseases, over the years TDR has expanded its disease focus and now works on issues relating to ten diseases. This expansion has, in part, resulted from external reviews and the review team are mindful that their recommendations have the potential for further change. The review was not designed to examine the current research portfolio in depth as this is being undertaken by another process. The comments that follow are therefore largely the views of the people interviewed during the review process. Despite this, there has been found to be considerable unanimity that there is an urgent need to refocus and rationalise both the disease focus of TDR and the research activities it engages in.

The considerable capacity which has been developed globally for HIV and TB suggests that TDR is unable to make a significant contribution in these areas although there continues to be a need to work closely with bodies who focus on these diseases. Research in these areas is costly and requires a significant body of expertise which should not be unnecessarily fragmented.

Likewise in the field of malaria there is also significant capacity developed elsewhere. Bi lateral donors and the BMGF have provided significant support for the Medicines for Malaria Venture (MMV) and the Malaria Vaccine Initiative (MVI).

The unit of TDR which focuses on malaria has, for some time had three out of its four scientists co-located in the Diagnosis and Treatment unit within the Global Malaria Programme of WHO. There is no doubt that TDR is making a significant contribution here in the areas of malaria diagnostics and community case management using operational research to identify feasible strategies,. A question remains however as to whether this is excellent and appropriate collaboration between two organisations with different remits (research support and normative function) or whether TDR is providing resources to undertake the core function of the GMP.

It is understood that there are already proposals to redistribute staff who currently work in this field to the NTD and Vectors units of TDR which would, de facto, have an impact on TDRs work in malaria and their ability to collaborate with the GMP.

Since the 2006 review TDR has also moved into the field of health systems research. There is general agreement that, however good individual members of the team may be, this is not an area where TDR has a comparative advantage. The emergence of the Alliance for Health Policy and System Research underlines this even though there has been a degree of complementarity in some work jointly undertaken. Whilst the two organisations worked together to arrange the Montreux conference, it is evident from interviews that the ongoing relationship is not synergistic, probably due to the perception that both organisations are in competition for resources.

12.2.1 Conclusions and recommendations

There is a strong groundswell of opinion that TDR has expanded beyond its core areas of advantage. Inevitably, some of this opinion arises from individuals in other organisations who feel they are in competition for resources. Never the less, there appears to be a valid argument that TDR should refocus on the traditional tropical diseases which attract less funding and impact strongly on poverty. This would mean a progressive withdrawal from work in HIV, TB and health systems.

There is not unanimity about whether TDR should withdraw completely from research associated with malaria given its significant past achievements relating to insecticide treated bednets (ITBN), the development of artemisine based antimalarial products; the development of the concept of home based management of malaria (HMM); and the work on the concept of pre-packaging to promote compliance, although more than one person has suggested that any continuing involvement should be either with countries or topics which are not covered by other programmes.

12.3 Research Functions

TDR's NTD team currently focuses on two research functions:

- Research for innovation, including diagnostics and drug development, in which TDR would engage strongly in the GSPoA process and
- Research for access and implementation coherent, with the increasing interest in health systems and operational research.

In undertaking the review, the team have taken an overview of what has been achieved in the past and what work is currently in train but has concentrated on identifying if there are unique areas where TDR has a “niche” which is not better filled by another body.

12.3.1 Product development (drugs and diagnostics)

Product development in the field of NTDs is historically difficult as the associated drugs and treatments are not generally significant revenue earners for pharmaceutical companies. This requires considerable influence with key players (mainly major pharmaceutical companies who may be persuaded on the grounds of social responsibility) but also expertise in licencing, intellectual property and other legal and process issues.

There is a real issue as to whether TDR has the resources or capacity to continue its involvement in product development. It has a strong history of success in this field in the past, but there is a feeling that it cannot now compete. There are concerns however amongst both scientists and funders that the withdrawal of involvement by TDR, which has in the past been perceived as a neutral and respected body, removes one of the “checks and balances” in drug development.

Having TDR as a Product Development Partner (PDP) gives considerable legitimacy but the partnerships can only work if TDR can devote the resources to add real value. There is anecdotal evidence that TDR has not been able to allocate staff time in the quantities originally envisaged in some initiatives and partners have lost confidence/ patience. This may be a result of inadequate initial costing with TDR staff being included in proposals as a “free good” paid for from undesignated funds, but this needs to be investigated in more detail

12.3.2 Drug development

In recent times TDR's role in direct drug discovery is being wound down and promising leads and project staff are being transitioned to other partners. There appears to be a move to utilising existing capacity and partnerships to assist in the establishment of regional networks of innovation and to transition projects, where possible, to these networks. One example is the African Network for Drugs and Diagnostics Innovation (ANDI)

In addition to the work of major pharma in this area, the creation of the Drugs for Neglected Diseases Initiative (DNDi) has brought another major player into the field. TDR was involved in founding DNDi and has a place on its board. However the relationship between the two bodies has, until very recently, not been easy. There was a feeling that TDR was too demanding and also that some areas of collaboration identified at technical level could not move forward due to lack of co-operation at more senior level. One area of successful collaboration has been identified and this relates to leishmaniasis in India where there are the structures for joint working. However, staff movements and lack of replacements is felt by DNDi to have endangered this. There has also been fruitful collaboration relating to malaria

DNDi has recently announced that it aims to identify and develop a pipeline of new treatments for lymphatic filariasis and onchocerciasis based on a different macrofilaricide flubendazole (i.e. a product capable of killing adult worms) This is an area which might in the past have been a natural development for TDR but also appears to run in parallel with the moxidectin trial undertaken by TDR formerly with Wyeth/ Pfizer.

In some ways TDR might see the work of DNDi as a success and a product of its aim to facilitate building the capacity to undertake product development. However, there is a feeling that there remains a degree of suspicion and competition although efforts have been made in recent months to overcome this and TDR staff are involved on the flubendazole development team

12.3.3 Diagnostics Development

TDR was exploring whether it should continue doing the work of comparison and validation of existing diagnostics but not product development at the time of the review although not final decision had been made. This will contribute to helping WHO in the procurement process by certifying quality of diagnostics, developing criteria for selecting the more reliable diagnostic tools and recommending these to countries. This work is done specifically for diagnostics in malaria, TB, dengue, and visceral leishmaniasis.

In general, it is recognised that PDPs have comparative advantage in discovery, development and testing.

The creation of the Foundation for Innovative New Diagnostics has provided another player in the field, although FIND does not cover all diseases focal to TDR. However, in the areas of malaria, tuberculosis and HAT, FIND is bringing together public and private sector partnerships, providing project management and progressing products from discovery, proof of principle to development, evaluation, WHO endorsement and implementation. This suggests that there is overlap and the potential for competition/ duplication in two of the diseases which TDR considers its current focus.

12.3.4 Outputs

There have been many successful outputs from TDR product development work over many years although this work has diminished over time with the emergence of new research support bodies. TDR continues to be involved in a number of clinical trials but increasingly “downstream” in field trials and implementation.

One of the major outputs expected from TDR in the recent period has been the development of a macrofilaricide drug (moxidectin) for onchocerciasis elimination. This major piece of work was originally undertaken in collaboration with Wyeth and, following the acquisition of the company, with Pfizer. Phase 2 results were presented in Abuja in December 2010 and it has now progressed to Phase 3 trials in three countries. However, scientists reported that there appear to be issues about both data quality and whether the Phase 2 findings justify moving to Phase 3 without further evidence although the official report of Phase 2 is not available.. Pfizer has withdrawn as sponsor from the moxidectin development.

12.4 Conclusions and Recommendations

The review confirmed the direction of travel already being followed in disengaging from product development in both drugs and diagnostics. With a number of other players involved in this area TDR does not appear to have comparative advantage at this time.. It does not have all the resources required to collaborate meaningfully. TDR should be congratulated however on its past work in developing the scientists who are now working in some of the new bodies including DNDi and FIND.

The research portfolio was being reviewed in parallel to this review and their recommendations should be read alongside this report

12.5 Research for Access and Implementation

With the involvement of social scientists, TDR has made a major contribution in some fields of implementation research. Notable amongst these has been home management of malaria which has been done in collaboration with GMP.

TDR has built on the work on community directed treatment in onchocerciasis by undertaking a major study across a number of countries evaluating the approach and its applicability to other diseases. It demonstrated that community compliance in the use of ITBNs and home administered antimalarials was impressive compared with conventional implementation approaches.

Interviews suggest that this is an area where TDR continues to have real comparative advantage and there are few other bodies who can undertake work of this sort, particularly across a number of countries. The review was not able to examine the quality or impact of individual pieces of research but this should be a product of the parallel review.

TDR has a network of collaborating partners with the infrastructure and capacity to collaborate on future initiatives of this sort. It has been reported that some multicountry research projects, while very worthwhile, have had long delays in their publications to the detriment of translating the findings into practice. This may be an inevitable consequence of the nature of the studies but the perception of interviewees was that delays were for other reasons.

The hosting of TDR by WHO provides the potential for close collaboration to facilitate implementation. Excellent communication needs to be systematically established to maximise benefit

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12.5.1 Recommendation

This should be strongly considered as a prime focal area in future.

12.6 Relationship with DEC institutions

TDR has a wide network of research institutions with which it works closely and it is evident that relationships are generally good. Institutions recognise the contributions made by TDR to research both in terms of funding and support. The contribution that empowerment/ capacity building has made to research being undertaken is acknowledged and felt to be a major strength of TDR in DEC.

Whilst there are DECs in Africa, Asia and South America there appears to be an issue about the extent to which TDR should support and fund research in all three regions. Some of the comments received undoubtedly reflect self interest on the part of interviewees home institutions/ locations but there appears to be a need to devise a transparent strategy as to:

- Whether TDR is truly global and thus attempts to use its resources equally across all DECs even where the burden of disease is small or the potential for research is limited
- Whether TDR should focus on DECs which are also LICs on the assumption that MICs have greater capacity as well as potential for obtaining research funding
- Whether TDR should focus purely where the burden of disease is highest (sub Saharan Africa)

There is a strong perception that some DECs have benefited disproportionately from TDR funding in the past. This was not possible to verify definitively as even the following breakdown of the recipients of grants will not reveal the totality of benefit to individual institutions or countries, given that some are subsidiary to the prime grant recipient. The percentage attributed to LICs are probably, therefore, a minimum figure with additional funds filtering down through the prime recipient. the figures below include funding for complementary capacity building.

Table 8

Income Group	2008	2009	2010	2011
LIC	\$6,269k 32.29%	\$5,703k 44.8%	\$6,778k 36.17%	\$2,984k 72.49%
Lower MIC	\$2,490k 14.02%	\$1,996k 15.68%	\$2,790k 14.89%	\$243k 5.91%
Upper MIC	\$1,827k 10.29%	\$1,967k 15.45%	\$1,804k 9.63%	\$231k 5.62%
HIC	\$7,175k 40.40%	\$3,063k 24.06%	\$7,369 39.32	\$658k 15.98

Source: *Based on 2010 World Bank classification (gross national income per capita)

**2010 data was extracted on 27 January 2011

***2011 data was extracted on 26 September 2011

It should be noted from the figures above that, proportionally, LICs have benefited in 2011 and this was a deliberate policy when funding became limited.

12.7 Quality Assurance

Over the past thirty five years TDR has had an excellent reputation for undertaking good quality research. There is every indication that, in the majority of instances, this is still the case. TDR has been recognised as both doing and funding high quality work and the proof of this is in the various contributions made to treat, control and eliminate NTDs.

In recent times however it is reported that there have been a number of projects which have experienced problems. Some of these have related to data quality/ data management and have necessitated changing the organisation responsible for data management.

This review was not tasked to examine individual projects although a parallel process is taking place. It will be important that this review can be demonstrably independent and that TDR is transparent about any quality issues revealed and what actions have been taken to prevent reoccurrence. This review is entirely independent of that evaluation of research

TDRs reputation both as a collaborator in research but also as a capacity builder relies on consistently applying the highest standards itself. Funders and partners need to be provided with evidence to reassure them on this issue as a matter of urgency given that there is inevitably speculation and rumour.

Whilst the responsibility for compliance with international standards and standard operating procedures is the responsibility of the principle investigator for any individual research initiative, Quality Assurance (QA) has become the responsibility of research coordination, termed the Research Management Support (RMS) unit since the restructuring in May 2011. In the past, QA activities have included training, monitoring and external audits. However, consideration is being given to expenditure for QA being reduced from the current budget of \$1.4m in 2010/11 which has already led to a cut in training activities may reduce still further.

There is a pool of 40 active monitors, many of which have been trained by TDR. Approximately 50% of the pool of monitors are reported by TDR to be of a high standard. Audits (routine and targeted) are carried out depending on study design, implementation issues and risk.

In most cases, when working for TDR, clinical trial monitors are unpaid except for per diems, This raises the risk of high quality monitors being unavailable as they can find more remunerative engagement in the private sector. this risk was mentioned by several interviewees although time did not allow further investigation.

There is a perception that opportunities exist for TDR to play a leading role in capacity building for monitoring in African countries but these cannot be currently capitalised on due to the budget cuts in this area. Interviewees suggested that monitoring skills could be acquired by other professionals (not just medical academics) including nurses. However using the centralized training centres, for example the one set up in Bangkok makes the process too expensive

There is no TDR wide system in place for QA, which is the responsibility of team leaders. Nor are there agreed standards which can be monitored routinely for compliance. The research management group provides support, for example by helping to organise clinical trials monitors. It is felt that research would benefit by developing a more systematic approach to QA. It is also felt that risk management processes relating to site selection, suitability of principal investigators and, project implementation would benefit from a more systematic assessment approach. These initiatives should be welcomed and given priority.

12.7.1 Recommendations

- Standards should be agreed across the organisation based on research SOP and monitored for compliance. The standards should be endorsed by the STAC and Cabinet
- Research would benefit from a more systematic approach to QA and risk management.
- Pay rates could be introduced to differentiate and retain high quality clinical trial monitors
- Opportunities for capacity building for monitors (including a wider range of disciplines) in African countries could be explored, depending on available funding.
- There may also be opportunities for synergies with empowerment, for example by organising for Gates Career Development Fellows who have gained experience in industry to spend time as monitors on clinical trial sites

12.8 Attribution of Research Findings

TDR can rightly claim to have supported a high percentage of the research undertaken in the field of NTDs over many years. There is an impressive tally of peer reviewed papers published in prestigious journals in each TDR report. There is no question that TDR has made a major contribution to this research, sometimes as prime or intermediary funder and often providing project management, quality assurance, technical support and personal training. In some cases TDR staff have been the first author in publications and it is therefore appropriate that this work is attributed to TDR.

A number of interviewees however feel that, on occasions, TDR has “claimed” research and thus diminished the position of the PI and the responsible organisation and the funding partner. This may be inadvertent but it has evidently resulted in a degree of discontent

12.8.1 Recommendation

TDR should review the way it reports achievement in research and be clear about what research is undertaken directly by TDR and its staff, what research is supported by TDR and those instances where TDR is primarily a funder.

12.9 Relationships with WHO regional offices, departments and control programmes

One of the main reasons for TDR being hosted as a special programme of WHO is the importance that research findings are translated into policy and practice. Whilst the relationships with some departments is clearly strong (notably GMP) it is much harder to find systematic and targeted dialogue and communication of research findings in some other areas. It is clearly important that control programmes reflect current evidence and that TDR contributes to implementation.

TDR has the capacity to contribute to implementation research as was proven in respect of the community directed treatment study and there would seem considerable potential for other initiatives of this kind working in partnership with other programmes and departments.

There are focal persons for NTD research in regional offices and, in principle they should be in a strong position to ensure that TDR research findings are fed into country policy dialogue. This is reported to be variable with some regions clearly having greater motivation (and relevance) and this is recognised as being an area of weakness where targeted communication would undoubtedly be supportive.

Annex 1 Terms of Reference

Interim External Review and Evaluation of The Special Programme for Research and Training in Tropical Diseases (TDR)

TERMS OF REFERENCE

09 August 2011

Introduction

The interim external review and evaluation is commissioned by TDR's Joint Coordinating Board (JCB) as a mid-term evaluation of TDR's ten year vision and strategy 2008-2013. This is a revised version of the original Terms of Reference approved by JCB (33) in 2010 that reinforces a managerial review and proposing an accelerated timetable as recommended by JCB (34). The objective is to assess how the work programme is progressing in the current strategy and evaluate the recent proposed changes in structure and management processes. The findings of the review will be examined by the TDR Scientific and Technical Advisory Committee (STAC) later in 2011 (through a Mini-STAC meeting) *and will inform donor decision making on further funding agreements*. The final report will be reviewed by STAC at its next full meeting in February 2012, the Standing Committee (March 2012) and the JCB(35) in June 2012. Upon request and guidance by the external review committee, TDR staff will be available to provide the necessary data and documentation and will be available for interviews and discussion. A brief self-assessment paper covering the period of 2008-2010 and outlining current plans for future development will be prepared by TDR to assist the External Review.

Background

TDR's Ten-year Vision and Strategy¹, endorsed by the Joint Coordinating Board (JCB) in June 2007, responded to the 4th External Review² recommendation for TDR to evolve and grow. The strategy was designed to streamline and, at the same time, expand the scope of the Programme and to introduce a results-based management approach. The goal was to reposition TDR and to strengthen its relevance in a dynamic and fast-growing landscape of initiatives on research and development (R&D) on neglected infectious diseases. The vision statement *"Fostering an effective global research effort on infectious diseases of poverty in which disease endemic countries play a pivotal role"* expresses TDR's engagement in three major functions:

***Stewardship**⁴ introduced as a new function to expand on TDR's original aspiration to become a major convenor of stakeholders around the identification of research priorities, knowledge gaps on specific diseases including cross-cutting thematic areas.*

Empowerment⁵ conceptualised as a further development of research capacity building activities, aiming to promote individual and institutional leadership in low and middle-income countries to develop priority-setting processes and to play a stronger role in partnerships.

Research on neglected priority needs⁶⁻¹⁴ which includes innovation for diagnostics and drugs R&D, evaluation of interventions and research for access, focusing on specific end-products where TDR has a comparative advantage.

A business line-based operational structure was introduced to improve efficiency by focusing on and delivering activities around clearly defined priorities, needs and end-products. A programme-wide Business Plan (2008-2013)³ was developed, including processes for technical management, external advisory systems, budgeting and continuous monitoring and evaluation at programmatic and at business line levels.

Each business line established a Strategic and Scientific Advisory Committee (SAC) to assist the managers on planning, monitoring and evaluating progress and to advise on funding recommendations. A TDR-wide monitoring and evaluation framework, developed in consultation with the co-sponsors, partners, the Scientific and Technical Advisory Committee (STAC) and others, was introduced to assess progress and ways of improving performance.

These functional changes were followed by a) appropriate redefinition of staff needs, reassignment of responsibilities and recruitments; b) more efficient internal managerial processes; and c) development of individual business line plans with defined output, outcomes and progress indicators. The new strategy began functioning in January 2008 and became fully operational after its first year with completion of the recruitment of several new business lines leaders.

The perception expressed by the 4th External Review² that TDR was undermanaged and over-administrated was corrected by prioritizing and consolidating a large and fragmented portfolio of activities into a more coherent and focused one. This led to a simplification of the planning and budgeting process, allocation of resources at the business lines level and streamlining contracting services.

At the end of 2010, revenue forecasting and an analysis in changes in strategic and technical trends identified an anticipated income gap. At the beginning of 2011, the strategy was revised and a financial recovery plan¹⁵ was put in place. The number of personnel was reduced and the portfolio of activities streamlined.

Reorganizing for greater efficiency

In May 2011, TDR completed the reorganization process based on the three strategic principles (i) stewardship and empowerment concepts should underpin all activities; (ii) there is a growing significance of innovation networks and developing country-based innovation for improved interventions; (iii) an increased emphasis on implementation research. This led to a consolidation of the original business lines structure into two technical areas: Stewardship and Empowerment as a merged function with three operational teams and Research on neglected priorities with four research teams (Figure 1).

(i) The number of research business lines was consolidated from nine to four teams:

- In the area of drug discovery there was a change of focus to promoting and supporting regional innovation networks under the framework of the global strategy and plan of action for public health, innovation and intellectual property (GSPoA).
- Diagnostics activities were streamlined within other lines of activity, in particular tuberculosis and malaria, and the stand-alone line on diagnostics was closed.
- Three disease-oriented teams were established addressing: (i) neglected tropical diseases, incorporating visceral leishmaniasis elimination; (ii) malaria; and (iii) TB/HIV.
- A cross-cutting research team addressing vector control, the environment and community research that further enhances the ability of TDR research to address issues across diseases as well as across sectors.

The following aspects were taken into account managerially:

- The Portfolio and Policy Development unit and Programme Management were merged into one single team to better link programmatic activities with finance and administration.
- The Strategic Alliances unit was closed.

The reorganization was carried out under the guidance and regulations of WHO. As a result of this process, TDR proposed a new streamlined organizational structure beginning May 2011 with a reduction of core staff positions, and is moving towards a planned reduced budget for the 2012-2013 biennium. A financial readjustment process is in place to address the financial gap and transition phase to next biennium.

Changing Scenario

TDR has intensified its engagement in global health research initiatives, partnered more extensively with WHO research and control-related programmes and has fostered stronger interaction with WHO regional and country offices and with national public health programmes. Some recent developments have opened new opportunities for TDR to grow, engage and extend its external outlook, scope and potential role:

- The Intergovernmental Working Group on Public Health, Innovation and Intellectual Property (IGWG), created through the World Health Assembly in 2006 and the resultant global strategy and plan of action on public health, innovation and intellectual property (GSPoA) approved by the World Health Assembly in 2008 (*Resolution WHA 61.21*)¹⁶
 - Within the GSPoA, the African Network for Drugs and Diagnostics Innovation (ANDI) was established, spearheaded by TDR with a goal of creating a sustainable platform for R&D innovation.¹⁷
- The development of a WHO Research Strategy with strategic functions in strong coherence with TDR goals. (WHA A62/12)¹⁸
- The renewed international commitment for research to strengthen health systems, galvanized through the Global Symposium on Health Systems Research, co-organized by TDR. (November 2010)¹⁹
- The evolving discussion on how global health initiatives interface with health systems infrastructure and delivery.²⁰
- WHO reform - a process for adapting WHO to the changing complexity of public health. (WHA A64/4)²¹

In discussions with STAC on how best to reorganize the research business line to respond more efficiently to external challenges and trends, two areas of work are consolidating: (1) research for innovation, including diagnostics and drug development, in which TDR would engage strongly in the GSPoA process and (2) research for access and implementation coherent, with the increasing interest in health systems and operational research.

With the JCB and Standing Committee, TDR has examined carefully the perspective of consolidating the current resource base, while at the same time expanding and diversifying alternative sources of funding to support the implementation of the plan of activities. STAC-32 appreciates the need to assess and assure the significant shift in TDR focus following the 4th External Review.

Purpose of the review

The purpose of this review is to take stock of achievements and to define the optimal strategic role for TDR in the future, drawing on lessons from the past 3-5 years. The review will also provide an objective measure for funders to inform their future investment decisions.

External Reviews of TDR are commissioned by the JCB as a regular process to provide an in-depth understanding of the Programme's effectiveness in the implementation of its vision, objectives, strategy and approaches, while also looking at how to strengthen its roles in the global agenda. The reviews should document successes, gaps to be filled, and make recommendations on how to sustain the current efforts, increasing relevance and internal and external coherence.

The Interim External Review will be carried out as a mid-term evaluation of the current vision and ten year strategy covering the years 2008 to 2011 and will provide the basis for further adjustment of the strategy if necessary. The review will assist TDR in the finalization of 2012-2013 budget and in the elaboration of the workplan and budget for the period 2014-2019.

The review should include short-term and long-term perspectives on how the programme is being implemented, its achievements and long-term vision, including its outreach, partnerships, and potential contribution to the overall context of the Millennium Development Goals (MDGs). This review is particularly timely as it will be available for the incoming new director of TDR, whose appointment is anticipated in early 2012.

Particular emphasis should be given to the proposed planning and management processes, including priority setting, monitoring and evaluation of activities, financial control and implementation and performance evaluation. The External Review should assess whether the administrative and managerial instruments in place are robust enough to anticipate and correct resources shortfalls in an efficient and effective way.

The external review of TDR is aligned with the WHO reform principles for adapting WHO to the changing public health landscape and to fulfil more effectively its role with greater coherence, improved outcomes, transparency and accountability.

Scope and focus

The review will be more limited in scope than the 4th External Review, but should cover an analysis of achievements against the overall vision statement of TDR in relation to the global health scenario. It will address the three basic strategic functions of TDR (Stewardship, Empowerment and Research on Neglected Priorities), using a limited number of indicators identified in the TDR performance assessment framework to demonstrate whether the strategy articulated was appropriate and whether TDR is on track. The review is expected to inform future strategic development of TDR and to contribute to efficient programme management

The proposed broad questions to be addressed by the review are formulated to cover five key evaluation criteria together with scientific quality:

1. Relevance

Are TDR's roles convening, building consensus, establishing priorities and promoting research and research capacity for neglected diseases valuable and still needed?

- *Is TDR addressing important challenges, needs and gaps?*
- *Are there any unnecessary duplications and how complementary are TDR's efforts to others working in the field of global health research?*
- *How does TDR work with others in the field, do partners benefit from TDR interaction?*
- *Is TDR sufficiently flexible to retain relevance and to respond to changes in the environment?*
- *Have recent changes in TDR been appropriate and strategic?*
- *How does TDR make future plans?*
- *Is the field better off with or without TDR?*

2. Effectiveness

How effective has TDR been in addressing the technical and policy recommendations of its scientific committees, STAC and JCB? Is TDR on track for achieving its proposed objectives and planned outputs for the 2008-2013 strategy?

- *If achieved, will the objectives deliver TDR's goals and will the activities deliver its objectives?*
- *Are risk management strategies fit for purpose?*
- *Could TDR be more effective in the field – and if so how?*
- *What are the specific limitations of TDR that should be addressed in the short, medium and long term?*

3. Efficiency

Are the three strategic functions and the revised managerial structure and portfolio appropriate and cost-efficient to deliver on the strategy?

- *Is TDR expenditure optimally balanced between the different activities?*
- *Are the internal systems fit for purpose?*

- *Is the internal structure fit for purpose?*

4. Impact

How has TDR contributed to the R&D landscape for neglected diseases, historically and within the review period?

- *What are TDR's main achievements – including tangible, perceived, intended, expected and unexpected?*
- *Identify the benefits where TDR has worked in partnership with others.*

5. Sustainability

Is TDR adequately prepared to sustain its past achievements and build on these into future biennia?

- *What organisational structures and activities are required for future sustainability?*

6. Quality of science

Is TDR's research of the highest quality and is scientific decision making independent and rigorous?

- *If not, what can be done to improve this?*
- *How well does TDR survey the wider research environment to ensure there is no duplication of effort?*
- *What steps are in place to ensure that all TDR commissioned/funded work is of the highest quality and is completed in time and within budget?*
- *Are project portfolios managed effectively in each operational unit and within TDR overall?*
- *How are issues around intellectual property handled?*

Stakeholder participation

The review should involve as much as possible a range of TDR stakeholder representatives to better review expectations, achievements and perceptions of the Programme. Interviewees should include members of TDR's governing bodies and scientific and advisory committees (in particular members of STAC and scientific committees), beneficiaries in developing and developed countries, partners in the public and private sectors, product development partnerships (PDPs) and donors.

Review methods

The review methodology will be established by the reviewers and may include but is not limited to the following:

- Analysis of TDR plans, portfolio of activities, annual reports and mapping of grants awarded;
- Review of external reports on TDR activities, including G-Finder²², FasterCures²³, Human Rights Council²⁴, TDR scientific peer-reviewed publications acknowledging TDR support;²⁵
- Interviews with stakeholders on TDR's perceived role, relevance and issues;
- Interviews with TDR and WHO staff.

An additional preparatory paper will be provided by the secretariat for the review. This will contain: a brief self-assessment of the period 2008-2010, proposed changes in financial management and administration, an extension of the vision and strategy options for 2014-2019 and critical elements for considerations for STAC and JCB moving forward.

Reviewers

The review will be undertaken by an organization with the assistance of selected experts experienced in programme evaluation, including public health and United Nations organization. A small panel of 3-4 experts should be engaged to assist the selected organization in formulating the review strategy, analysis and reporting as an integral part of the review and evaluation process. These members should have a multidisciplinary background and broad knowledge of the field of research for health and social development. The members should not have applied for or received grants or financial support from TDR within the past five years and should not have served on any TDR Advisory Committee within the same period.

Report delivery date

The deadline for completing the review and submitting a final report is **10 November 2011**.

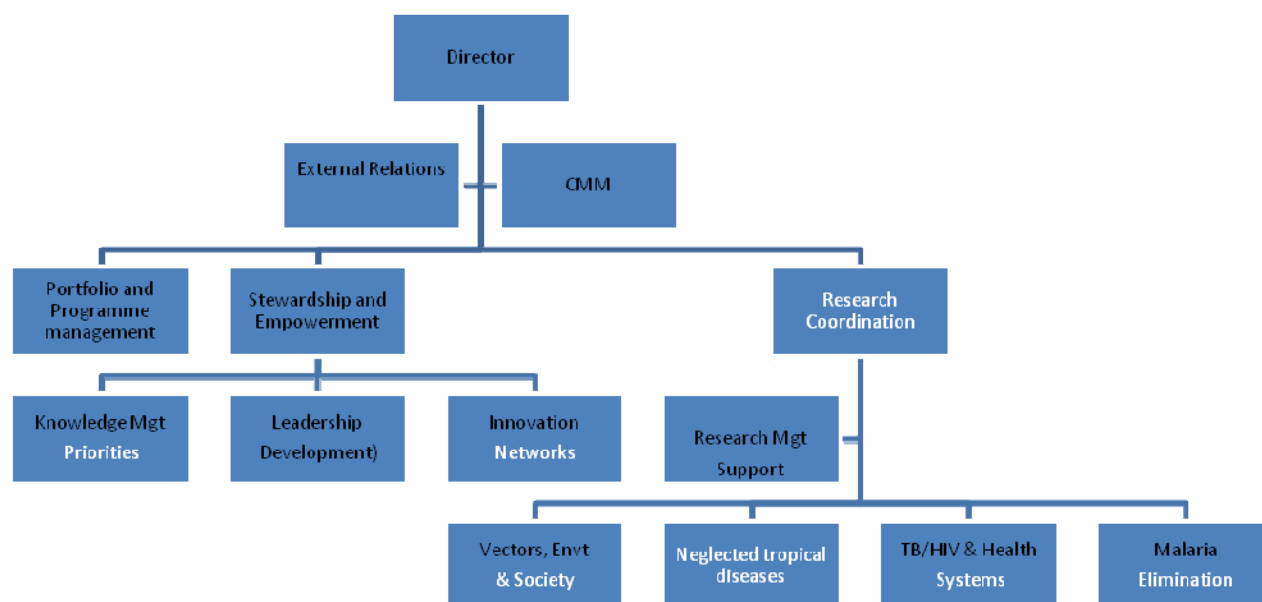
This short deadline was established by TDR Joint Coordinating Board taking into account that some funders would like to see the report before making funding decisions for the next biennium. The report will also be reviewed by a subgroup of the Scientific and Technical Advisory Committee (STAC), 22-23 November, by the full STAC in April 2012 and finally by the Joint Coordinating Board in June. TDR staff will be available during the conduction of the review to provide documentation, feed-back and clarify any issue.

Budget

TDR has reserved US\$ 100,000 for the Interim External Review process.

Annex 2

Figure 1 - TDR Organigram



Annex 3 List of People Interviewed

Name	Designation
Achidi, Eric Akum	Department of Medical Laboratory Sciences, Faculty of Health Sciences, University of Buea, Cameroon
Agbayani Marion	Technical Assistant, Portfolio Management, TDR
Akuffo Hannah	SIDA and Karolinska Insitute
Aslanyan Garry	Knowledge Translation, Knowledge Management & Priorities, Stewardship TDR
Atun Rifat	Director – Strategy, Performance & Evaluation Cluster, The Global Fund
Ballasegaram, Manica	Head of Leishmaniasis Clinical Program, Drugs for Neglected Diseases Initiative (DNDi)
Baritt Hans	Chief Accountant, WHO
Bejerano Maria Teresa	SIDA
Binka Fred	University of Ghana
Bockarie Moses	Centre for Neglected Tropical Diseases Liverpool School of Medicine
Bosman Andrea	Global Malaria Programme, WHO
Cappuccini, Paolo	Finance Assistant, Programme Management, TDR
Certain, Edith	Knowledge Management, Tropika, TDR
Cunningham Jane	Malaria Research for Elimination, TDR
Devlin, Michael	Head of Communication, ICARDA Research Center (formerly with COHRED)
Ehrenberger, John	Head of Division of Communicable Diseases, Western Pacific Regional Office/WHO
Fairlamb Alan	University of Dundee
Faiz, Abul	Sir Salimullah Medical College, Bangladesh
Farrar Jeremy	Co Chair of DRG on dengue and other viral diseases of public health importance
Feigh, Christine	Director of Communications WHO
Fidler Armin	World Bank(SC)
Francois Annabel	Assistant, Programme Management, TDR

Interim External Review and Evaluation of The Special Programme for Research and Training in Tropical Diseases (TDR)

<i>Name</i>	<i>Designation</i>
Gaffar, Abdul	Director of the Alliance for Health Policy and Systems Research
Gomez Melba	Manager Malaria, Clinical and Evaluative Research, Neglected Diseases, TDR
Guth Jamie	Manager communications, TDR
Gyapong, John	Professor , Pro-Vice-Chancellor (Research Innovation & Development), University of Ghana
Halleux Christine	Professional Officee, Neglected Tropical Diseases, TDR
Halpaap Beatrice	Manager Portfolio and Programme Management TDR
Handjani, Farhad	Professor, Shiraz University of Medical Sciences, Iran
Hemingway Janet	IVCC
Ijsselmuiden, Carel	Director of Council on Health Research for Development (COHRED)
Jupp, Susan	Global Forum for Health Research
Kengeya Kayondo Jane	Unit Leader, Leadership development, Stewardship, TDR
Kieny Marie-Paule	ADG, WHO and Acting director TDR
Kinn Sue	Chair. DFID
Kioy, Deborah	Scientist, Biomedical Science, Knowledge Management & Priorities, Stewardship, TDR
Kivenjinja Salim	Technical Officer, Finance and Contracts, TDR
Lang Trudie	Oxford University
Launois Pascal	Individual Leadership Development, TDR
Lee-Martin Shook-Pui	Interin Programme Officer, TDR
Lissner Craig Louis	Priogramme Manager, RHR/WHO
Mandel Evie	Chief Budget Officer, WHO
Masoudi, Abdul	Administrative Assistant, TDR
Matta Issa	Senior Legal Officer, WHO
Mbacham, Wilfred	University of Yaounde, Cameroon
Mbizvo Michael	Director Reproductive Health Research
Mihut Michael	Portfolio policy and development, TDR
Mills, Anne	Professor of Health Economics and Policy, London School of Hygiene and Tropical Medicine (LSHTM)

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Name	Designation
Molyneux David	Co Chair of DRG on zoonoses and marginalized infectious diseases
Moussy Francis	Unit Leader, Knowledge Management & Priorities, Stewardship, TDR
Mshinda Hassan	COSTECH Tanzania
Mulengo Modest	Director Tropical Diseases Research Center, (Vice chair JCB)
Murilla Grace	Director, Trypanosomiasis Research Centre, Kenya Agricultural Research Institute
N'Doungu, Joseph	Head, Human African trypanosomiasis and other neglected Diseases, FIND
Ntoumi, Francine	Congolese Foundation for Medical Research
Nwaka Solomon	Leader, Innovation Network Stewardship, TDR
O'Malley Dr Jeffrey	UNDP (SC)
Oduola, Ayoade	Coordinator Stewardship and Empowerment, TDR
Ogundahunsi Olumide	Empowerment. Capacity building institutional, TDR
Olliaro Pierro	Leader, Neglected Diseases Research, TDR
Pagnoni Franco	Malaria Research for Elimination
Pecoul Bernard	Director DNDI (new drugs NTDs)
Perkins, Mark	Chief Scientific Officer, Foundation for Innovative New Diagnostics (FIND)
Rabello Ana	Fundação Oswaldo Cruz (FIOCRUZ), Brazil
Rodriguez Dr Mario Henry	Chair, Director, National Institute of Public Health, Ministry of Health, México
Ronse Ignace	Belgium Representative (JCB)
Samuels, Gill	Executive Director of Science Policy and Scientific Affairs, Europe, Pfizer Global Research and Development
Savioli Lorenzo	Director, Control of Neglected Diseases (NTD WHO)
Studer Meinrad	Manager, External relations and governing bodies, TDR
Tang Shenglan	TB/HIV and Health Systems TDR
Toure Yeya	Leader, Vectors, Environment & Society, TDR
Vahedi Mahnaz	Research management support, TDR
Velez-Bernal Ivan Dario	University of Antioquia, Medellin, Colombia

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<i>Name</i>	<i>Designation</i>
Vennervald Birgitte	Danish Bilharzia Laboratory University of Copenhagen)
Willingham Lee	Scientist, Vectors, Environment & Society
Young Mark	UNICEF (SC)
Zicker Fabio	Coordinator, Research on neglected priority need, TDR

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