Type of Review: Annual Review

Project Title: Medicines Transparency Alliance

Date started: 4 August 2011 Date review undertaken: 27 June 2013

Introduction and Context

What support is the UK providing?

DFID funded the pilot phase (May 2008 – Dec 2010) of the Medicines Transparency Alliance (MeTA) in seven countries; Ghana, Jordan, Kyrgyzstan, Peru, Philippines Uganda and Zambia). DFID is now providing £6 million over 4 years to MeTA Phase 2 (henceforth stated as MeTA) to support these countries in:

i. bringing civil society, private sector and government together to collect, share and analyse robust data on medicine price, availability, quality and promotion

ii. using evidence to inform better policies and to improve practice/systems in the pharmaceutical sector (both state and non-state) that will increase the access of the poor to affordable, quality life-saving drugs

iii. innovating new tools, technologies and knowledge management systems to improve the quality and availability of pharmaceutical data and strengthening accountability for access to medicines, particularly to communities

This support is provided through the International MeTA Secretariat (IMS), comprising the World Health Organisation (WHO) and Health Action International (HAI)

What are the expected results?

Impact - MeTA will contribute to an increase in access to safe, effective and affordable essential medicines, particularly for the poor. It is anticipated that MeTA will increase access to medicines – measured by the average availability of selected essential medicines in public and private facilities at the baseline or lower real prices (consistent with MDG 8, target 17) - by 10%, and result in cost-savings of 5% - 10% in public sector expenditure. This is equivalent to £18m - £36m, based on estimated total per annum public expenditure across the seven pilot MeTA countries.

Additional, and potentially more significant, savings are anticipated in private expenditure. In four of the five pilot countries for which data is available (Jordan, Kyrgyzstan, Peru, Philippines and Zambia) private out-of-pocket expenditure on medicines is 1.25 – 24.9 times the equivalent public expenditures. This phase will incorporate efforts to better quantify private expenditure and potential efficiency savings.

Outcome - MeTA will contribute to the development of effective access to medicines policies that are informed and monitored by robust and timely information and evidence on the price, availability, quality and/or promotion of medicines.

The outputs of MeTA will be (a) effective and appropriately funded multi-stakeholder processes in MeTA countries (b) appropriate and timely technical support provided to MeTA countries to inform policy analysis and development (c) new field tested methodologies to collect, analyse and/or share routine information on medicines (d) increased international engagement with MeTA (new funders, endorsements by external stakeholders, use of MeTA resources) (e) an independent evaluation of MeTA against the baseline established during the pilot phase.
MeTA also has a number of important potential indirect benefits. Improved transparency and accountability in the provision of medicines may contribute to reduced corruption, and improve market conditions for reputable businesses that may otherwise be undercut by low quality, unregulated medicines providers. Improved availability of medicines can increase confidence in public sector services, and improve overall health service utilisation. Medicines are significant contributors to health expenditures. Improved efficiency and reliability of medicines procurement can significantly contribute to progress towards universal coverage of basic health services. As noted above, improved access to affordable medicines can also contribute to poverty reduction, by reducing potentially impoverishing household expenditures on medicines and by contributing to better health outcomes (and thus averting the impoverishing impacts of ill-health).

What is the context in which UK support is provided?

Improving health outcomes in developing countries is constrained by poor access to medicines. Average availability of essential medicines in public sector facilities in developing countries is just 34%. People are frequently driven to the private sector where availability of medicines is higher (at 63.2%) but prices are often unaffordable. The World Health Report (2010) notes that medicines account for 20% - 30% of global spending on health and that, “reducing unnecessary expenditure on medicines and using them more appropriately, and improving quality control, could save countries up to 5% of their health expenditure.”

The UK has established itself as a significant thought leader and important donor in supporting increased access to medicines. The UK invests in research to develop new health technologies; takes leadership in international policy debates relevant to access to medicines (such as on trade, intellectual property and access to medicines); provides significant funding to global financing mechanisms that are major purchasers of medicines (such as the Global Fund to Fight AIDS, TB and Malaria); and works with countries to strengthen health systems to support better access to medicines. However the poor quality, availability and timeliness of information on medicines in many developing countries remain significant barriers to increasing access, providing value for money and improving accountability. MeTA is an innovative approach to working with governments, civil society and the private sector to increase transparency and accountability for access to medicines in 7 countries. Evidence from the pilot and programme monitoring shows that when government, private sector and civil society organisations work together, there is more and better information available to inform policies on medicines.

This phase of MeTA aims to show that better information will lead to better medicines policies, and in turn to greater access to medicines. Continued UK commitment to the principles of transparency and accountability in the pharmaceutical sector will be used to help leverage commitments by other donors.
## Section A: Detailed Output Scoring

<table>
<thead>
<tr>
<th>Output 1: Functioning multi-stakeholder groups exist and have national government support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Output 1 score and performance description:</strong> Output met expectation: A</td>
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<tr>
<td><strong>Progress against expected results:</strong></td>
</tr>
<tr>
<td><strong>Indicator 1.1:</strong> Multi-stakeholder groups (MeTA Councils) exist where government, private sector and civil society are represented and meet at least biannually in each country</td>
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<tr>
<td><strong>Milestone:</strong> MeTA Councils implement transparency principles (achieved)</td>
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<tr>
<td>Each implementing country has a MeTA Council with an implementing secretariat that can receive funding. Workplans have been developed cooperatively and transparently and have been signed off by the International MeTA Secretariat (IMS) (the managing agent). The MeTA Councils agree to MeTA principles and build these, where relevant, into their workplans; these are:</td>
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<td>- Governments are responsible for providing access to health care, including access to essential medicines.</td>
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<tr>
<td>- Stronger and more transparent systems and improved supply chain management will increase access.</td>
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<td>- Increasing equitable access to medicines improves health and enables other human development objectives to be achieved.</td>
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<td>- Improved information about medicines can inform public debate and empower customers and patients.</td>
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<tr>
<td>- A multi-stakeholder approach that involves all sectors (private, public and civil society) will lead to greater accountability and provide a basis for better policy.</td>
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<tr>
<td>Adherence to the last of these has increased in the last year. In 2012, Only Jordan, Zambia and the Philippines had adequate and active representation on MeTA councils from the public and private sectors and civil society; in 2013 all seven countries had adequate representation and had resolved initial challenges. Factors facilitating this change included participation by representatives from Ghana and Uganda in the Peoples Health University course in South Africa; discussions between IMS and Ministries of Health (MoH) in Peru and Uganda; and the appointment of a coordinator in Peru and Zambia.</td>
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<td>In Ghana, Civil Society capacity for engagement is relatively weak, though enthusiasm is high; the MeTA Council secretariat has been given funds to support civil society activities to improve engagement. In Kyrgyzstan the private sector is now more fully engaged and has been active in recent discussions of the countries medicines policy, alongside civil society. MeTA Zambia still struggles with governance and financial/administrative capacity; a new fundholder has been selected that will allow for more rapid transfer of funds and improved communication.</td>
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<tr>
<td><strong>Indicator 1.2:</strong> MeTA Councils produce an annual workplan approved by the IMS</td>
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<td><strong>Milestone:</strong> All MeTA Councils produce an approved workplan (achieved)</td>
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<td>All countries have produced workplans using a broadly consistent structure, but with different levels of sophistication (according to secretariat capacity) and with different activities, based on the different needs of the countries. Most have described a monitoring system, but only 1 (Ghana) has produced a timeline with clear responsibilities.</td>
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<tr>
<td><strong>Indicator 1.3:</strong> Number of MeTA Councils supported from country level sources (domestic or donor; cash or in-kind)</td>
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<td><strong>Milestone:</strong> Four MeTA Councils have country contributions (more than achieved – achieved in all seven countries)</td>
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<td>The MeTA Secretariat in each country has estimated in-kind donations, based estimated market values. Total contributions are estimated at over GBP 150,000 and include office and meeting space; teleconference facilities; printing; data collection costs; staff; IT equipment; free publication of policies in</td>
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a fee-paying journal; participation for MeTA councils in workshops on the Rational Use of Medicines and Monitoring of Antimicrobial Consumption in non-EU countries; and costs of a press-conference on the European Antibiotic Awareness day.

Recommendations:

- The workplans should undergo regular review and revision to ensure they remain relevant. Many could also be improved through the inclusion of a timeframe, a note of institutions responsible for fulfilling key activities and a more clearly articulated monitoring plan.
- The evaluation should identify the relative efficiency, effectiveness and cost-effectiveness of MeTA councils led by public sector, private sector or civil society organisations.

Impact Weighting (%): 20%
Revised since last Annual Review? N
Risk: Medium
Revised since last Annual Review? N

Output 2: Capacity built in countries to collect and analyse data, using innovative methods as required.

Output 2 score and performance description: Output met expectation A.

Progress against expected results:

Output indicator 2.1: Number of MeTA relevant surveys/or data collation exercises (including monitoring) conducted with local team participation

Milestone: 1 per year per country collecting at least a subset of indicators relevant to outcome 1 (more than achieved)

This output was scored as ‘C’ last year, since there was insufficient evidence to demonstrate that the milestone had been met. Recommendations made during the annual review have been addressed appropriately (including rewording the output to its current formulation to make its meaning more clear). This year the milestone has been met. Data collection plans were built into the workplans, operational procedures were established and data collection for a subset of indicators is either complete or underway in six of the seven countries; in Zambia it was deemed that sufficient data had been collected during the pilot phase to develop plans to improve transparency in the sector. The data relates to policies and/or practices relevant to medicines procurement, pricing and distribution.

Countries are using different data collection tools. Some are innovative, using new technologies (e.g. mobile phone applications); some are innovative uses of routinely collected data; and others are using established and appropriate tools. Data will be used to improve rational use of medicines; quality and/or pricing; and procurement and supply. Some countries are capitalizing on policy assessments funded by other agencies (WHO, EU and SARPAM). One (Philippines) is looking for means of recognising private sector organisations that ensure transparency in their processes.

Indicator 2.2: Number of new indicators and tools to measure availability, affordability and prices developed and validated by MeTA

Milestone: New tool piloted (achieved)

There is no expectation of piloting new tools in all countries, however many countries will be using tools new to them. The Monitoring of Medicines Availability and Price (MMAP) tool is an innovative tool used through mobile phones that a number of countries have expressed interest in. Needs assessments are complete or underway in Ghana, Jordan and Uganda. Ghana has proposed a methodology for data collection, but implementation will be delayed until new medicines policies are in place. Ghana’s experience with the MMAP needs assessment led to improvements in the
methodology, including a review and gaps analysis of existing data. The assessment also looks at which stakeholders would use additional data, why and how.

Other tools include the following. A Knowledge, Attitudes, Behaviour and Practice (KABP) previously used for vertical programmes is being modified for broader use with selected CSOs and will be piloted in the Ghana. Kyrgyzstan is newly using an anti-microbial use data collection methodology. A promotions assessment tool, developed during Phase 1 of MeTA is being piloted in the Philippines (www.medicinetransparency.org/meta-toolbox/medicines-promotion-assessing-the-nature-extent-and-impact-of-regulation). The Ministry of Health in the Philippines is re-launching a revised electronic price monitoring system and MeTA is monitoring progress.

Indicator 2.3: Number of analytical reports based on surveys and other data highlighting policy issues and making recommendations
Milestone: Output 2.1 report (more than achieved)
The six countries that have data collection processes in place will have reported by the end of the project year (August 4 2013). Reports against Output 1 from Kyrgyzstan and Peru are available electronically; others will be available through the IMS secretariat. Additionally reports based on data collected during the first phase of MeTA are forming the basis of policy discussions.

Indicator 2.4: Number of analytical and other reports agreed by MeTA councils and Ministry of Health
Milestone Y2: Output 2.1 report agreed (moderately not achieved)
Countries will discuss reports in MeTA Councils by the end of this project year. Those that have been discussed in MeTA councils already include the MMAP needs assessment in Ghana and the assessment of the National Medicines Policy in Kyrgyzstan.

Recommendations:
- A regular review of the range of data being collected and its potential to contribute to the assessment of MeTA outcomes should be conducted
- Where new technologies are used for data collection, an evaluation of those methods should be undertaken, ideally comparing costs of the tools and the quality of the data collected through them with other data collection methods (NB: the DFID policy research fund may be able to support the evaluation of such tools)
- IMS should continue to focus on and review data quality and use, whichever tool is used
- Outstanding reports should be discussed by MeTA councils and with the MoH as soon as is possible (recognising that some plans for this for some reports are underway)
- IMS should promote sharing of lessons between the different MeTA countries to support transfer of appropriate techniques or concepts where possible (e.g. lessons from Peru’s Observatory shared with the Philippines)

Impact Weighting (%): 20%
Revised since last Annual Review? \(N\)
Risk: Medium
Revised since last Annual Review? \(N\)

Output 3: Transparency and accountability of the pharmaceutical sector strengthened

Output 3 score and performance description: Output met expectation \(A\).

Progress against expected results:
Indicator 3.1: Reports from output 2 disseminated to relevant stakeholders
Milestone: One report disseminated to stakeholders (more than achieved)
This milestone has been more than achieved through the work of MeTA Kyrgyzstan and MeTA Peru.
The National Medicines Policy recommendations were widely disseminated by e-mail, through the MoH website (www.med.kg), a news agency (www.kg.akipress.com), the MeTA Kyrgyzstan website (http://metakg.org) and two large multi-stakeholder roundtable events. The results of the antimicrobial use survey from non-EU countries will be published in the Lancet Infectious Diseases. MeTA Peru has made its median price report publicly available at: www.digemid.gob.pe/Precios/ProcesosL/Publicaciones/Publicaciones.aspx?over=1. This report is based on data from the price observatory. It provides information to consumers for purchasing decisions and to providers and payers (e.g. insurance companies) to improve their procedures and lower medicines-related costs. Median price data is published in the DIGEMID web site.

Indicator 3.2: Information (from reports from output 2, reports from the pilot, and other information) disseminated using appropriate messages and methods to other stakeholders

Milestone Y2: Key messages identified. Dissemination methods identified (achieved)

The MeTA website now has links to reports from many of the country programmes. Beyond this different countries are developing their own information dissemination strategies; Jordan, Kyrgyzstan and the Philippines have made most progress toward targeted communications for different audiences. Issues for dissemination include the use of generic medicines; quality of medicines; rational use of classes of medicines (e.g. antibiotics and painkillers); the need for early diagnosis of illness; and medicines compliance

Recommendations:

- Countries that have made less progress with dissemination plans should be supported to progress these
- A brief paper outlining key messages, audiences and dissemination methods for each country could be produced to provide cross-programme learning
- Where possible, the success of communicating key messages to different audiences should be evaluated

Impact Weighting (%): 10%
Revised since last Annual Review? N

Risk: Medium
Revised since last Annual Review? N

Output 4: Civil Society Organization capacity to support improvements in transparency and accountability of the pharmaceutical sector strengthened

Output 4 score and performance description: Output met expectation: A

Progress against expected results:

Indicator 4.1: Specific indicators are country dependent and should therefore be established by country. May include: understanding of issues, ability to collect/analyse data, and/or dissemination of information.
Milestone: To be established by country

Capacity building milestones need to be country specific. The milestones for each were established during year 2 but the logframe has not yet been amended to reflect these. The following presents the milestones selected by each country and progress made against them. This output has been scored as an A, since progress against the set milestones clearly has been made.

MeTA Ghana: Understanding of Issues
Milestone: Development of a new tool for CSO capacity development
The Ghana Coalition of NGOs in Health, is an umbrella organisation for over 500 working in health, operating throughout all the country’s regions. Its constituent CSOs need training to better understand medicines issues. MeTA Ghana has developed, and will pilot, a capacity gap assessment tool; funding is being managed by the MeTA Council to accelerate the engagement of CSOs in the process. It is hoped that this tool will be transferable to other countries.
MeTA Jordan: Full engagement of Civil Society in all aspects of MeTA workplan delivery

*Milestone: CSO representation at all technical meetings*

The members of the CSO Health Alliance have some technical knowledge on medicines issues but were previously excluded from policy development discussions. The WHO country representative and IMS explained the value of involving civil society to policy makers and CSOs are now involved in all technical committee meetings. This will lead to in-service capacity building for CSOs with regard to policy making. The CSO Health Alliance has also prepared a proposal for capacity building for CSOs on advocacy, communication and responsible use of medicines through workshops with all stakeholders and capacity building of patients’ societies.

MeTA Kyrgyzstan: Ability to disseminate information and inform stakeholders

*Milestone: Preparation and implementation of comprehensive work programme*

Two applications for civil society awareness-raising have been received and initial funding provided. These relate to (1) right of the public to access State Health Insurance programs and (2) the public right to have access to quality medicines. Information from the first provinces has been collected; preparation for subsequent regions is ongoing.

MeTA Peru: Engagement of Civil Society in all aspects of MeTA workplan delivery

*Milestone: Enabling Civil Society to have a consolidated voice*

Civil society in Peru has been somewhat fragmented; there are many vocal actors, but with little coordination between them. Partly as a consequence of this, and compounded by weak administrative capacity, civil society had been sidelined by the MeTA council. Now a CSO is the fundholder and is able to organise and attend MeTA council meetings. The management capacity of the CSO has been strengthened through guidance on the financial package and reporting requirements being given by HAI’s financial director.

MeTA Philippines: Understanding of the Issues

*Milestone: CSO community monitoring tool developed and project underway*

A tool, indicators, implementation framework and training module for a community monitoring project have been developed. The work will be contracted in July 2013.

MeTA Uganda: Engagement of Civil Society in all aspects of MeTA workplan delivery

*Milestone: Civil society as lead fund-holder and secretariat to MeTA Uganda*

HEPS, a CSO is now the lead agency in MeTA Uganda. HEPS is planning to share information on access to medicines issues with community groups and train them on routine data collection relating to medicines and health status.

MeTA Zambia: Engagement of Civil Society in all aspects of MeTA workplan delivery

*Milestone: Civil Society is an independent fundholder and MeTA stakeholder*

Implementation of MeTA activities has been accelerated by changing the MeTA fundholder from Transparency International to the pharmaceutical society of Zambia (PSZ). PSZ have received training on the financial management package under the guidance of HAI.

*Indicator 4.2: Second indicator on CSO capacity building to be defined by countries as needed.*

*Milestone: The second milestone is only established in country if it is deemed necessary*

MeTA Ghana, Uganda, Zambia: Understanding of Issues

*Milestone: Training of young CSO ambassadors*

Young civil society ambassadors from Ghana, Uganda and Zambia attended the Peoples Health University in Cape Town. Key areas of learning were: access to medicines (accessibility, pricing, safety of products, rational use of medicines, and domestic pharmacy use); challenges of lack of political will and policy implementation; the impact of trade agreements on health systems; the role of activists in increasing access to and quality of services; and new analytical frameworks, tools for engagement and skills for working with communities.

MeTA Uganda: Ability to collect and analyse data and/or dissemination of information

*Milestone: Programme development*

MeTA CSOs expressed their concern over stock-outs of Essential Medicines and Health Supplies with an
emphasis on HIV test kits and blood test kits. They resolved to (1) collect more evidence, (2) develop a statement and (3) hold a press conference. Training for this activity will take place in July 2013.

MeTA Zambia: Understanding of Information

*Milestone: To conduct awareness campaigns on pricing, quality, and availability of medicines.*

Civil society members of the MeTA council will broadcast radio and TV programs to transmit messages relating to access to medicines to the general public. Public Pharmaceutical Procurement Officers will be trained by civil society in accountability and transparency issues.

**Recommendations:**
- A note below the logframe needs to be made outlining the milestones for each country for each year
- Review civil society engagement to assess whether some types of institutions are more effective than others and/or whether a minimum level of technical knowledge is required for effective engagement
- Review potential for the Ghana KAPB tool to provide basis for such a review
- Identify opportunities for countries within a region to strengthen each other’s capacity

**Impact Weighting (%)**: 10

**Revised since last Annual Review?** N

**Risk**: Medium

**Revised since last Annual Review?** N

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Output 5: Policy makers in MeTA countries engage in multi stakeholder policy dialogue to develop new or review access to medicines policies

**Output 5 score and performance description:** Output met expectation A.

**Progress against expected results:**

*Indicator 5.1: Minutes from MeTA and other meetings with policy makers where medicines are discussed*

*Milestones: There were no milestones for year 2.*

Although no specific progress was expected against this output until year 3, MeTA Kyrgyzstan has already demonstrated achievement in this area. It has been leading the stakeholder dialogue concerning the Kyrgyzstan National Medicines Policy. So far it has organised two roundtable discussions with policy makers and other key stakeholders; the second was attended by around 120 delegates, including members of the IMS.

*Output Indicator 5.2: Number of policy recommendations based on multi-stakeholder policy dialogue agreed and proposed to MOH*

*Milestones: There were no milestones for year 2.*

As for indicator 5.1 MeTA Kyrgyzstan has made progress on policy development a year before it was expected to do so. It has proposed revisions to the National Medicines Policy to the MoH, based on the multi-stakeholder dialogue outlined above.

**Recommendations:**

Review the indictors for this output and change if improvements can be made to reflect quantity and
Output 6: International engagement with MeTA increases

Output 6 score and performance description: Output met expectation A.

Progress against expected results:

Indicator 6.1: Percentage of MeTA support from additional funders (national and international)
Milestone: Support is maintained at year 1 level (exceeded)

GBP 78,000 has been donated by the World Bank Institute to MeTA Uganda members to fund specific MeTA projects, under a CSO social accountability programme. These are:

- Strengthening multi-stakeholder groups (2012): USD 10,000
- Data collection on medicine availability in 4 districts: USD 30,000
- Survey on client satisfaction with medicine procurement and supply chain management: USD 80,000

Indicator 6.2: Utilisation levels for MeTA information and methodology resources. Dissemination of MeTA information and methodology resources
Milestone: Users, page views and downloads of/from platform increased by 5% compared to first year

The original website coding does not allow Google analytics to accurately show any statistics for the site. A consultant will now maintain the international website and will report on relevant statistics.

In addition to the global website, websites have been restarted in Ghana, Kyrgyzstan, and Peru. Ghana in particular is important because the website had been hi-jacked by a commercial firm. A new address (metaghana.net) has been established and the website has been populated.

The WHO website also has links to MeTA pages at: http://www.who.int/medicines/areas/coordination/meta/en/.

Indicator 6.3: Number of collaborations with Stakeholders (e.g. Academic Institutions, NGOs, Bilateral and International organisations)
Milestone: Six collaborations with MeTA initiated (achieved)

The collaborations are as follows:

- Ghana: the WHO Renewed Partnership for African, Caribbean, Pacific Countries will collaborate on the assessment of the National Medicines Policy and the development of pricing policy.
- Jordan: Synergies with the Good Governance for Medicines programme are being sought.
- Uganda: The World Bank has officially joined MeTA as a participating member to collaborate on transparency in procurement.
- Zambia: SARPAM will assist with in country data collection and data analysis. There may be further collaboration with the WHO Renewed Partnership for African ACP Countries.
- Globally:
  - WHO and USAID are collaborating on the Medicines Library. This will expand access to and dissemination of information at country level on full text articles from WHO, partner and government documents.
Interns from Utrecht University School of Pharmacy have assisted with country profiles.
HAI has conducted workshops in transparency in access to medicines at Rijks Universiteit Groningen, Universiteit Utrecht, Vrije Universiteit and the University of Amsterdam.
HAI has provided support and guest lecturers to University of Griningen, a Latvian workshop attended by policy makers, civil society and others. A fellowship with Kings College London will allow for further teaching on access to medicines issues.
IMS secretariat was Guest lecturer at the Ghana Pharmacists Association annual conference.

Recommendations:
None

Impact Weighting (%): 10%
Revised since last Annual Review? N
Risk: Low
Revised since last Annual Review? N

Output 7: External evaluation of MeTA outcomes against baselines established during the pilot phase

Output 7 score and performance description: Outputs moderately did not meet expectation B.

Progress against expected results:
Indicator 7.1: Independent external evaluation carried out.
Milestone: Planning of the evaluation; collection of information (moderately did not meet expectation B)

TORs for the evaluation have been developed with input from IMS and are being finalised with input from DFID’s evaluation quality assurance unit. The contract will be tendered when the documents have been finalised.

Recommendations:
- Contract to be tendered as soon as possible (by DFID)

Impact Weighting (%): 10%
Revised since last Annual Review? N
Risk: Low
Revised since last Annual Review? N

Section B: Results and Value for Money.

1. Progress and results

1.1 Has the logframe been updated since last review?

Yes. Revisions have been made to better articulate the likely impact of and outcomes from MeTA and to capture process issues that are more closely linked to results. Additionally the inclusion of indicators for civil society capacity building have been requested; these have been reported against for the current year, but future years need to be included in the logframe, for each country, as an addendum. All changes were discussed and agreed to by DFID and the IMS and shared with MeTA Councils in all
seven countries in order to align country workplans with overall MeTA objectives, outcomes and outputs.

Changes agreed to the logframe:

Impact indicator 3
Changed from: Estimated efficiency savings through reduced prices/treatment costs, efficient procurement and appropriate use of medicines
To: Efficiency savings through reduced prices, appropriate use of medicines and/or less waste according to country priorities.

Milestones
Y1 Deleted: Definition of a methodology to aggregate efficiencies
Y2 Changed from: Testing of efficiency methodology
To: Means of measuring efficiency savings are defined.
Y4 Added: Each country measures efficiency savings against baseline

Target
Changed from: 'aggregate' efficiency savings in MeTA pilot countries
To: Efficiency savings are realized

Output 6
Changed from: International engagement with MeTA increases
To: Engagement with MeTA Increases

Output Indicator 6.1
Changed from: % MeTA support from additional funders (national and international)
To: MeTA support (in cash or in-kind) from additional sources (national and international)

Milestones
Y2 Changed from: 15%
To: Support is at least maintained at year 1 level
Y3 Changed from: 30%
To: Support is at least maintained at year 1 level

Target
Changed from: 50%
To: 15% Support is maintained at year 1 level in all MeTA Countries

Output Indicator 6.2
Changed from: Utilisation levels for MeTA information and methodology resources
To: Dissemination of MeTA information and methodology resources
Y3 Added: Presentations to or other form of participation in complementary programmes or events
Y4 Added: Meeting held with international donors, partners and stakeholders.

Target
Changed from: Users, page views and downloads of/from platform increased by augmented by 30% compared to first year.
To: International and national donors, partners and stakeholders have received MeTA information; Users, page views and downloads of/from platform increased by augmented by 30% compared to first year.

Output Indicator 7.1
1.2 Overall Output Score and Description:

A: Outputs met expectations

1.3 Direct feedback from beneficiaries

MeTA has two main types of beneficiaries. The primary beneficiaries are patients who should have more access to medicines as a result of MeTA interventions. The benefits to them are articulated at the impact level of the programme and are expected to be seen in the last year of the programme. It was not appropriate therefore to obtain feedback from these beneficiaries at this stage in the programme. The intermediary beneficiaries are policy makers and the other stakeholders in the MeTA council. The programme intends to benefit them by making more data available for policy making and by providing a forum to ensure broad dialogue on medicines issues. DFID Policy Division has not visited MeTA Councils in the last year, however we have been in touch with health advisers in DFID priority countries who have contact with council members. In Zambia the MeTA council is aligned with medicines policy development in country and appears to have a good composition of stakeholders. In Ghana the MeTA council progressed slowly at first and as a consequence a development partner representative stepped off the council; however since then progress has been more rapid, workplans are being implemented and key workplan milestones are allied to the logframe milestones.

The other direct feedback we have seen has been correspondence to the IMS from MeTA Kazakhstan, who have very much welcomed the support provided to them and who are using the multi-stakeholder platform to facilitate broad engagement in policy discussions.

1.4 Summary of overall progress

MeTA has made substantial progress this year in all countries. The challenges that were experienced in the first year, as a result of the lapse in time between the pilot and MeTA Phase 2, have been overcome: the MeTA councils are functioning, have developed workplans and have begun implementation. The level of progress varies by country and in some places has only been achieved following a change in lead institution.

Clearest progress has been seen in Kyrgyzstan, Jordan, the Philippines and Uganda. In Kyrgyzstan, MeTA has been central to the inclusion of civil society and the private sector in discussions on the national medicines policy. In Jordan a strong platform for intervention has been developed with equal partnership by civil society, which had previously been very weak. The Philippines MeTA Council has continued to function effectively and has started collecting data on medicines promotion practices and on transparency within the supply chain. MeTA Uganda has identified synergies with other civil society programmes and facilitated them to attract additional funding.

The most encouraging area of progress has been on data collection in each country, which will provide the basis for evidence-based policy dialogue next year.

A key driver behind the improvements has been the willingness of the IMS to address the recommendations arising from the previous annual review (Quest: 3607428). All recommendations were addressed and have been documented. Among these, the implementation of an exit criteria warning system has particularly stimulated progress because it has highlighted to MeTA Councils that they are off-track and simultaneously triggered additional support from IMS.
1.5 Key challenges

Uganda, Peru and Zambia all faced challenges at the start of the year due to weak administrative capacity. In all three countries the fundholding agent has been changed to one with greater convening power. Consequently, capacity building in these countries has focused on financial management and financial control.

Ghana and Zambia received ‘yellow card’ warnings during the reporting period for delays in meeting agreed deadlines for workplan development. IMS have provided additional support and both countries have now made substantial progress.

IMS working arrangements: HAI and WHO continue to work as a single secretariat, sharing responsibility and increasingly dividing workload responsibility. They are finding, however, that supporting seven countries with their existing capacity and resources a challenge.
1.6 Annual Outcome Assessment

MeTA has made good progress and has achieved most milestones, though progress is still needed on some. Based on achievements to date we expect the project to meet its outcomes by 2015. In addition to the logframe outcomes, we expect the evaluation to provide new knowledge on promoting transparency and accountability within a sector. Progress against outcome indicators with year 2 milestones is noted below.

**Outcome: Medicines procurement, pricing and other policies are changed on the basis of a Multi-stakeholder review of robust evidence**

*Outcome Indicator 1: Each MeTA Council demonstrably uses robust pharmaceutical sector data to monitor and review access to medicines*

*Milestone: At least one source of data on access to essential medicines reviewed by MeTA council and findings of review minuted.*

Each country has collected data on key medicines issues, however many have not yet discussed the findings with the MeTA Councils. In many cases these are due to be discussed by the end of the programme year as shown in the table below:

<table>
<thead>
<tr>
<th>Data collected</th>
<th>MeTA Council discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ghana</td>
<td></td>
</tr>
<tr>
<td>MMAP needs assessment</td>
<td>21 March 2013</td>
</tr>
<tr>
<td>Assessment of DTCs</td>
<td>End June 2013</td>
</tr>
<tr>
<td>Jordan</td>
<td></td>
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<tr>
<td>NDP assessment</td>
<td>July 2013</td>
</tr>
<tr>
<td>RDU policy assessment</td>
<td>July 2013</td>
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<tr>
<td>Disclosure policy assessment</td>
<td>July 2013</td>
</tr>
<tr>
<td>MMAP need assessment</td>
<td>July 2013</td>
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<tr>
<td>Kyrgyzstan</td>
<td></td>
</tr>
<tr>
<td>NDP assessment</td>
<td>May 2013</td>
</tr>
<tr>
<td>Antimicrobial use</td>
<td>March 2013</td>
</tr>
<tr>
<td>Peru</td>
<td></td>
</tr>
<tr>
<td>Median drug prices report</td>
<td>July 2013</td>
</tr>
<tr>
<td>Philippines</td>
<td></td>
</tr>
<tr>
<td>Mapping of entitlement programmes</td>
<td>June 2013</td>
</tr>
<tr>
<td>Uganda</td>
<td></td>
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<tr>
<td>DTC assessment</td>
<td>July 2013</td>
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<tr>
<td>MMAP needs assessment</td>
<td>July 2013</td>
</tr>
<tr>
<td>Zambia</td>
<td></td>
</tr>
<tr>
<td>Pilot Data Assessment</td>
<td>July 2013</td>
</tr>
</tbody>
</table>

*Outcome indicator 2: Each MeTA council demonstrates commitment to principles of transparency through collection, publication and dissemination of robust information on pharmaceutical price and availability.*

*Milestone: Data for outcome indicator 1 2013 milestone verified independently and published in sources available to key stakeholders.*

Ghana, Peru and Kyrgyzstan have all made timely progress against this outcome. The remain countries indicate that progress will be made in the near future, however it is not yet clear that this is possible, nor how widely and through which mechanisms reports will be disseminated. Expected dates for dissemination of data are provided in the table overleaf.
<table>
<thead>
<tr>
<th>Assessments</th>
<th>Dissemination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ghana</td>
<td>MMAP needs assessment</td>
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<tr>
<td>Assessment of DTCs</td>
<td>MeTA Council to decide</td>
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<td></td>
<td>July 2013</td>
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<tr>
<td>Jordan</td>
<td>NDP assessment</td>
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<tr>
<td></td>
<td>RDU policy assessment</td>
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<td></td>
<td>Disclosure policy assessment</td>
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<td></td>
<td>MMAP need assessment</td>
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<td></td>
<td>August 2013</td>
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<td>August 2013</td>
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<tr>
<td>Kyrgyzstan</td>
<td>NDP assessment</td>
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<td></td>
<td>Antimicrobial use</td>
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<tr>
<td></td>
<td>Submitted to Lancet Infectious Disease</td>
</tr>
<tr>
<td>Peru</td>
<td>Median drug prices report</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.digemid.gob.pe/Precios/ProcesosL/Publicaciones.aspx?over=1">www.digemid.gob.pe/Precios/ProcesosL/Publicaciones.aspx?over=1</a></td>
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<tr>
<td>Philippines</td>
<td>Mapping of entitlement programmes</td>
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<td>July 2013</td>
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<td>Uganda</td>
<td>DTC assessment</td>
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<td>August 2013</td>
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<td>August 2013</td>
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<tr>
<td>Zambia</td>
<td>Pilot Data Assessment</td>
</tr>
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<td></td>
<td>July/Aug 2013 (Consultant TBC)</td>
</tr>
</tbody>
</table>

**Outcome indicator 3: Policy makers in MeTA countries use multi stakeholder policy dialogue recommendations to develop new or review access to medicines policies**

**Milestone: Review from outcome 1 used to identify new policy requirements or policy amendments**

Countries that have experienced delays in outcome 1 are consequently experiencing delays in this area, however many are using data collected during MeTA’s pilot phase to inform policy dialogue. The timing of policy discussions is often rightly dictated by national processes rather than the MeTA Council.

Kyrgyzstan has already used data collected during the current phase of MeTA to support the drafting of policy recommendations; an assessment of Ghana’s National Medicines Policy will take place in August 2013 and will use information gathered during MeTA’s pilot phase. In Jordan technical working groups are assessing three areas of policy using information collected in the pilot phase.

In Peru data is being used to inform policy, but is also being used by the Ministry of Health and others to improve medicines practice: the online Digemid/MeTA Price observatory has received 1,458,000 hits since its inception and legislators regularly request reports on specific medicines or therapeutic areas.

### 2. Costs and timescale

#### 2.1 Is the project on-track against financial forecasts: Y

To date, DFID has disbursed:

- HAI: £1,074,600
- WHO: £1,372,968

All financial reporting has been timely and accurate.

#### 2.2 Key cost drivers

This budget is sufficient to cover the core running costs of the International MeTA Secretariat. The key cost drivers are staffing and travel, which is primarily used to support in-country technical work. Additional funding is being provided for capacity building and for some areas of national workplan activity, notably data collection.
2.3 Is the project on-track against original timescale: Y

Progress is broadly on track, though some milestones remain to be met. This is partly a function of the early timing of the annual review (six weeks before the end of the programme year)

3. Evidence and Evaluation

3.1 Assess any changes in evidence and implications for the project

No new evidence that challenges the project design or rationale has emerged since the first annual review. The theory of change was not very clearly articulated in the Business Case, but is receiving more attention through the design of the evaluation. The logframe assumptions remain valid. The evaluation will increase the wider evidence base on the benefits of greater participation and transparency in policy making.

3.2 Where an evaluation is planned what progress has been made?

Terms of reference were drafted in partnership with the IMS. They have been shared with DFID’s governance advisors, since the evaluation will focus primarily on hypotheses around the role of transparency and accountability in policy development and implementation. They have been evaluated and reviewed by external quality assurance and are in the process of being amended. Contracting is expected to occur in the next two months.

4. Risk

4.1 Output Risk Rating: Medium

4.2 Assessment of the risk level

In the original business case the risk level was deemed to be high. The business case stated that “The impact of MeTA is potentially significant, as the programme aims to improve both the efficiency of pharmaceutical markets and sector, and governance and accountability for access to medicines outcomes. However, the approach is high risk and slower to deliver returns than typical logistics reform and distribution systems support.”

This remains true, however the risk pertaining to each output is low or medium due to the capacity of the IMS to manage the risks, giving the project an overall risk rating of medium. The project management team remain aware that the outputs of the logframe and indicators will need continuous monitoring throughout the project.

4.3 Risk of funds not being used as intended

Both Health Action International (HAI) and the World Health Organisation (WHO) have provided DFID with timely and accurate reports.

The IMS have also given all countries “Administrative and Budgetary Guidance for Submission of MeTA Country Workplans’ which gives practical guidance on the submission of budgets and some countries have received additional financial management training and support.
4.4 Climate and Environment Risk

The main climate concern highlighted in the business case was the frequency of flights between MeTA countries, the UK, Amsterdam and Geneva. Climate impact is being reduced by holding telephone meetings where possible between DFID and the IMS and the IMS and MeTA Councils and by holding face to face meetings when participants have been in the UK or Geneva for other purposes.

5. Value for Money

5.1 Performance on VfM measures

MeTA is an inherently catalytic project, not designed to make large investments in commodities, delivery systems, staffing or infrastructure. It is designed to improve the availability, quality and use of relevant medicines information and to strengthen accountability mechanisms. It is explicitly designed to add value to broader investments in pharmaceutical and health systems.

There are six indictors in the MeTA logframe that could support a value for money analysis:

Impact:
- Increased average availability of a core set of essential medicines in selected countries
- Reduced mean of prices of a core set of quality essential medicines in selected countries
- (Revised) Efficiency savings through reduced prices, appropriate use of medicines and/or less waste according to country priorities.

Outputs:
1.3 Number of MeTA Councils supported from country level sources (domestic or donor; in cash or in kind)
6.1 Proportion of MeTA support from additional funders (national and international)
- Availability of an independent evaluation. [quantification and validation of results]

The impacts will be measured as MeTA progresses; results are not expected to be realised until Year 3. Some progress against output 1.4 has been seen, with resources (largely, but not exclusively, in kind) being provided by domestic partners to the MeTA councils. Progress has also been made toward leveraging international funds through discussions concerning partnerships with international development partners being initiated in four MeTA countries, notably the World Bank in Uganda. An independent evaluation is soon to be contracted.

Where possible, efforts to drive economy in procurement are made for all cost drivers (staffing, travel, capacity building and data collection).
- Staffing costs have been incurred by HAI. HAI benchmarks its staff salaries against the CAO Welzijn, (the Dutch Government Labour Code Agreement) which ensures comparable salaries with other NGOs and ensures they are able to attract the right skills at market rates. No pay awards have been made for the past four years under CAO welzijn.
- WHO also incurs staff costs, both at HQ and in each of the seven MeTA countries. MeTA contributes to salaries (cost sharing) of existing positions and at country level recruits national experts for cost efficiency purposes. Salaries are in line with the UN scale, like any other UN agency and within this scale, positions and grades correspond to well established competencies and tasks to be carried out. Within the MeTA project no overtime can be charged.
- Travel costs are incurred by WHO and HAI according to each organisation’s travel policy; for WHO business class travel may only be used for travel exceeding 9 hours. HAI travel economy for all flights. In all cases flights are secured well in advance of travel date in an effort to reduce cost and HAI is able to take advantage of a discounted ‘NGO’ seats with some carriers, when on travel duty for a registered NGO.
- Capacity building costs are contracted locally and are put out to competitive tender where necessary. Efforts are also made to ensure civil society and/or MeTA Councils are resourced where possible through donated office space and equipment, meeting rooms, printing, WHO country logistics and administrative support. This is highlighted elsewhere in the annual review.
- Data collection costs are undertaking through routine systems where possible (at zero additional cost) and using cost-effective technology where feasible. Where data collection is contracted out, a competitive tendering process is used. This often involves existing WHO/HAI tools, and the use of WHO country offices meeting rooms for planning and training workshops, logistics and administrative support for country data collection.

5.2 Commercial Improvement and Value for Money

HAI has a Procurement Policy (QUEST 3094972) which sets out the guidelines that HAI staff follow to ensure value for money in every aspect of their procurement. HAI have submitted a complete commercial capability review (QUEST 3099240).

The Multilateral Aid Review reported that WHO has systems in place to review organisation effectiveness. There is evidence that procurement is driven by value-for-money. [http://www.dfid.gov.uk/About-DFID/Who-we-work-with/Multilateral-agencies/Multilateral-Aid-Review-summary---World-Health-Organisation-WHO/](http://www.dfid.gov.uk/About-DFID/Who-we-work-with/Multilateral-agencies/Multilateral-Aid-Review-summary---World-Health-Organisation-WHO/)

5.3 Role of project partners

HAI and WHO jointly comprise the International MeTA Secretariat and are jointly responsible for providing support and training to the implementing partners and broader MeTA Councils at country level.

HAI has not procured anything high-value on behalf of DFID. Low value, low volume procurements, such as office consumables, are sourced from three separate suppliers on an ad-hoc basis and costs are compared on each occasion. When HAI procures it compares like-for-like tenders. DFID has not felt the need to request details on all low value procurements as this only totals £5,480 of the £537,300 given to them to run MeTA.

WHO (Essential Medicines and Pharmaceutical Policy Department – EMP) provides technical assistance to national MeTA Councils through in-country staff, regional and HQ staff and WHO network of international experts (including Collaborating Centres). WHO procures technical assistance on behalf of DFID under their agreed MOU.

5.4 Does the project still represent Value for Money: Yes

5.5 If not, what action will you take?

N/A

6. Conditionality

6.1 Update on specific conditions

Not applicable.

7. Conclusions and actions

The Medicines Transparency Alliance Phase 2 project has met expectations, having significantly accelerated progress since the first annual review. Attention to programme implementation is still required to ensure that the MeTA remains on track in subsequent years.
The following actions are proposed:

Output 1:
- The workplans should undergo regular review and revision to ensure they remain relevant. Many could also be improved through the inclusion of a timeframe, a note of institutions responsible for fulfilling key activities and a more clearly articulated monitoring plan (MeTA Councils with oversight from IMS. Ongoing; note of next review by December 2013)
- The evaluation should identify the relative efficiency, effectiveness and cost-effectiveness of MeTA councils led by public sector, private sector or civil society organisations (To be highlighted by DFID in the evaluation design by September 2013)

Output 2:
- A regular review of the range of data being collected and its potential to contribute to the assessment of MeTA outcomes should be conducted (IMS. Ongoing, but with report of initial review by March 2014)
- Where new technologies are used for data collection, an evaluation of those methods should be undertaken, ideally comparing costs of the tools and the quality of the data collected through them with other data collection methods (NB: the DFID policy research fund may be able to support the evaluation of such tools). (IMS to make DFID aware of new technologies as they are being planned and discuss potential for research.)
- IMS should continue to focus on and review data quality and use, whichever tool is used (IMS. Ongoing, but with report of initial review by March 2014)
- Outstanding reports should be discussed by MeTA councils and with the MoH as soon as is possible (recognising that some plans for this for some reports are underway) (MeTA Councils. By Dec 2014)
- IMS should promote sharing of lessons between the different MeTA countries to support transfer of appropriate techniques or concepts where possible (e.g. lessons from Peru’s Observatory shared with the Philippines) (IMS. Ongoing, but with lesson sharing plan to be reported to DFID by March 2014)

Output 3:
- Countries that have made less progress with dissemination plans should be supported to progress these. (MeTA Councils to produce them by December 2013 with IMS support)
- A brief paper outlining key messages, audiences and dissemination methods for each country could be produced to provide cross-programme learning (IMS. February 2014)
- Where possible, the success of communicating key messages to different audiences should be evaluated (MeTA Councils by March 2015)

Output 4:
- A note below the logframe needs to be made outlining the milestones for each country for each year (IMS. Logframe to be reviewed by January 2014)
- Review civil society engagement to assess whether some types of institutions are more effective than others and/or whether a minimum level of technical knowledge is required for effective engagement (IMS. By April 2014 and with a plan articulated for institutional change where needed)
- Review potential for the Ghana KAPB tool to provide basis for such a review (IMS by January 2014)
- Identify opportunities for countries within a region to strengthen each other’s’ capacity (IMS. Ongoing, but with a draft concept by April 2014)

Output 5
- Review the indicators for this output and change if improvements can be made to reflect quantity and quality of outputs (DFID and IMS by January 2014)

Output 7
- Contract to be tendered as soon as possible (by DFID)
8. Review Process

The IMS provided a comprehensive report which is saved in QUEST. Health advisers in Ghana, Uganda and Zambia were asked for their views on MeTA’s performance in those countries. The DFID health adviser (Gillian Mann) reviewed material from these sources and submitted this annual review.

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