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Swiss Centre for International Health

UNITAID

ESTHERAID Project – End of Project Evaluation

Final Report

Swiss Centre for International Health at the
Swiss Tropical and Public Health Institute

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List of abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
CAR	Central African Republic
CHAI	Clinton Health Access Initiative
CMS	Central Medical Store
DLES	Direction de la Lutte contre les Endémies Spécifiques (Directorate for the fight against Specific Endemic Diseases)
EF	Expertise France
EID	Early Infant Diagnosis
ESTHER	Ensemble pour une Solidarité Thérapeutique en Réseau (French Acronym)
FEI	France Expertise Internationale / French international expertise (public establishment)
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
MoH	Ministry of Health
MoU	Memorandum of Understanding
M&E	Monitoring and Evaluation
MSH	Management Science for Health
OIG	Office of the Inspector General (of the Global Fund)
PCR	Polymerase Chain Reaction
PLHIV	Person/people living with HIV
PSM	Procurement and supply management
SOP	Standard Operating Procedures
Swiss TPH	Swiss Tropical and Public Health Institute
TAC	Treatment Action Campaign
TB	Tuberculosis
TCC	Treatment and Counselling Centre
ToR	Terms of Reference
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
VFM	Value for Money
VL	Viral Load
WHO	World Health Organization

Executive Summary

In 2007 UNITAID and Ensemble pour une Solidarité Thérapeutique en Réseau (ESTHER) explored the possibility of building a partnership. In five African countries - Benin, Burkina Faso, Central African Republic (CAR), Cameroon and Mali where ESTHER was already working, the availability and usage of paediatric and second-line antiretroviral (ARV) drugs at treatment centres remained limited because of 1) the ARV supply management system was deficient; 2) erratic Procurement and Supply Management (PSM) and patient data management resulted in quantifications and forecasts not being made properly; and 3) the demand for paediatric and second-line ARVs was low and/or irregular as diagnostic and monitoring tools of people living with HIV (PLHIV) were insufficient.

During its 8th Session (2-3 July 2008) the UNITAID Executive Board approved a resolution authorising the UNITAID Secretariat to commit USD 15,950,000 over a three year period towards the ESTHERAID Project[1]. On 3 July 2009, the UNITAID and ESTHER, i.e. the Parties, entered into an Agreement following which ESTHER undertook to implement a Preliminary Evaluation and Planning Phase of the ESTHERAID Project (referred to as the "Phase 1 Agreement"). The Phase 1 Agreement was originally entered into for a period of eight months but was subsequently extended twice, until the 1st April 2011. The Phase 1 Agreement envisaged that, upon evaluation and approval by UNITAID of the Phase 1 results, UNITAID would enter into a further agreement with ESTHER for the operational and implementation phase of the ESTHERAID Project ("Phase 2"). A Memorandum of Understanding (MoU) was concluded by the Parties on 22 December 2010, establishing the terms of collaboration by the Parties during Phase 2, to facilitate and secure the availability of ARV treatments and their proper administration to PLHIV in five African countries. The MoU provided that the starting date of the Phase 2 Project would be the 1st January 2011 and that the Term would be three (3) years. However, in accordance with the MoU, its duration could be extended by a written amendment, signed by the Parties. On 10 July 2013, ESTHER submitted a formal request to UNITAID for a one year no-cost extension of the Phase 2 Project. On 24 July 2013 the Parties mutually agreed to extend the duration of the Term of MoU until 31 December 2014.

The project had three main outputs: 1) to improve PSM systems; 2) to optimise identification, treatment and monitoring of patients in need of paediatric and second-line ARVs at selected treatment facilities; and 3) to improve the measurement of ARV drug use and needs through drug inventory and patient monitoring systems at treatment facilities. Each output had its performance monitored by at least two indicators.

The project focused on building capacity of staff from the government health sector in treatment sites. No commodities were to be purchased by ESTHERAID. Medicines, reagents and other commodities were expected to be purchased directly by the government or procured through other projects.

As part of the evaluation methodology, carried out by a team of consultants from The Swiss Tropical and Public Health Institute (Swiss TPH), it has been agreed with UNITAID that the

[1] Resolution available at: http://www.unitaid.eu/images/Resolutions/EB8/English/utd_eb8_res1_en.pdf
The details of this section came out of the 'First Amendment Providing for a No-Cost Extension of the Memorandum of Understanding Dated 22 December 2010 for Phase 2 of the ESTHERAID Project', which provides the complete timeline of the project.

team would meet with former project coordinators at Expertise France (EF)[2] in Paris, before conducting field visits in CAR and Cameroon. Information about the three remaining countries was obtained by sending questionnaires to key informants in each country.

The main purpose of the evaluation was to assess the overall performance of the project, as well as lessons learned, guided by a list of key questions from UNITAID. This final report also includes a limited analysis of the project's sustainability, i.e. an assessment of its performance at the time of evaluation, roughly 18 months after the end of the project.

The "relevance" section explains why the project does align with UNITAID's mission to innovate for HIV/AIDS treatment and with the global response to HIV/AIDS.

The "effectiveness" section provides a detailed account of the results and achievement ratios of the seven output indicators measuring the performance of the three project outputs. For the five indicators related with training and setup of management tools results and achievement ratios confirmed the effectiveness of the ESTHERAID project. The more modest results related with ARV stock-outs and Viral Load testing may be explained by the fact that the project did not control all necessary inputs. Results and achievement ratios showed notable differences across the five countries. Based on visits to facilities and conversations with local health providers, the evaluation team had a positive impression of the project's achievements during the field visit in Cameroon and CAR.

The "efficiency" section shows how the project managed to meet its timeline and budget. In fact, the mid-term evaluation conducted in December 2012 and January 2013 point to the necessity of extending the project by 12 months. As a result a one-year no-cost extension was signed between ESTHER and UNITAID in July 2013. By the end of the no-cost extension, 85% of activities had been completed, with some differences across individual countries, partly because of the political context (military intervention in Mali in 2012; political unrest in CAR between March 2013 and early 2015).

The "impact" section describes the project's performance measured by goal indicators 1 and 2. The average achievement ratio was 98% for indicator 1 – number of children under ART – and 60% for indicator 2 – number of adults and children under 2nd line ART. The relatively lower performance for indicator 2 was the consequence of a 'very limited access to viral load'. The unit cost per new patient treated during the project's duration was 4'732 EUR. It should be noted that this amount was obtained by dividing per-country expenses related with the strengthening of all components of HIV case management (PSM, healthcare providers' knowledge, laboratory capacities, community interventions and data collection and reporting) by the number of new patients enrolled in the cohorts over the project's duration.

The "sustainability" section reports and analyses observations made during the field visits to Cameroon and CAR, as well as answers made by key informants in the three other countries.

The main lessons learned are summarised as follows:

- The ESTHERAID project did a remarkable work within the limits established by the MoU signed between ESTHER and UNITAID in December 2010, according to which no

[2] Since January 2015 ESTHER has merged with another six government agencies to become Expertise France (EF).

resources would be allocated to the purchase of equipment, medicines and laboratory reagents. However, ESTHERAID might have obtained even better results if medicines and reagents had been more readily accessible. Stock-outs did affect the project repeatedly.

All five countries reported ARV stock-outs until the very end of the project implementation, thus leaving little indication that the problem would be durably solved after the project period. On the opposite stock-outs of paediatric and 2nd line ARVs would continue in all probability to be a recurrent annoyance.

- A project that solely builds capacities, without the necessary resources to procure equipment, medicines and laboratory reagents, either on its own or through a formal partnership with a commodity supplier, runs the risk of repeated shortages or stock-outs. ESTHERAID expected other well-established donors (the Global Fund, the World Bank, etc.) would meet procurement needs. The fact that ESTHERAID was affected by repeated stock-outs shows that procurement activities were anything but smooth. In the past few years, three international organizations or programmes (West African Health organisation, U.S. President's Emergency Fund for AIDS Relief/PEPFAR, and the United Nations Children's Fund/UNICEF) have set up or considered setting up emergency commodity stocks in West Africa to provide limited quantities of products whenever planned procurements would be delayed. Whatever the focus, any future project should study appropriate ways to minimise the risk of stock-out.

- Not only did ESTHER spend a significant amount of time during the preparation phase to discuss and develop each country plan with government health authorities, along national strategies, it also managed the project with the necessary flexibility (with UNITAID's approval) to respond to local problems. Flexibility was particularly appreciated when project's interventions had to navigate Mali's and CAR's political instability.

- The evaluation team did not fully perceive the benefit associated with working concurrently in five countries. Although they shared a number of similarities, they also differed in terms of strength of their health sector and stability.

- UNITAID's decision to limit the project's initial duration to three years was probably overambitious. A no-cost extension provided nine extra months of field activities (until September 2014) and 12 months to close the project (until December 2014).

- Health professionals leaving their position shortly after being trained and being replaced by newcomers unfamiliar with procedures are a regular occurrence in many developing countries. There is no simple fix to this problem. Developing reference and operation manuals and distributing them widely during the project was one of the solutions adopted by ESTHERAID. Having health professionals trained so as to organize retraining after the end of the project was another option. However, the lack of funding in some countries prevented retraining from occurring. Through other projects ESTHERAID did secure limited funding to keep some activities going on after 2014, but most funding stopped after 2015.

- Future projects should have their exit strategy fully spelled out in their operational plan, just like other activities. ESTHERAID did have a written exit strategy, published in June 2014. The introductory statement that the ESTHERAID project was "by nature sustainable" may be seen *a posteriori* as rather overoptimistic.

- Key informants in Burkina Faso and in Mali reported that the ESOPE patient data management system was operating smoothly in Mali and satisfactorily in Burkina Faso.[3] The evaluation team had a different perception in Cameroon and CAR, where financial issues and technical problems affected the system. Key informants in Benin reported a similar experience. Most of all, the system was significantly underused, except for one medical doctor at the Hôpital Central in Yaoundé. Although no decision was made at the time of our visit, the usefulness of the ESOPE system was being questioned by Cameroon's MoH.

Four recommendations are intended for UNITAID as follows:

1) For a future project focusing on capacity-building, a complex and time-consuming undertaking, UNITAID should consider extending the duration from three to five years. If duration cannot be lengthened, UNITAID should consider implementing it in a smaller number of countries, to streamline and speed up management and coordination.

2) A future project similar to ESTHERAID should partner with an emergency commodity fund/stock to minimise the risk of stock-outs. Alternative options include setting up a specific emergency stock for the project, contributing to setting up a national emergency plan in each project country, or closely partnering with a procurement project such as the Global Fund to Fight AIDS Tuberculosis and Malaria (the Global Fund).

3) A future project aiming at improving ARV accessibility by paediatric or second-line PLHIV through capacity-building should include the 'HIV retention rate' indicator that complements the two indicators related with coverage of interventions.

4) UNITAID could have been more demanding from ESTHER/EF in terms of reporting some of the results in the final report 2014. Had ESTHER/EF exploited the stock-out data as indicated in the log frame, the indicator O1.1 would have yielded much more information than it did. Likewise, the results of the three training related indicators, O1.2, O2.2 and O3.3 should have considered project and non-project participants separately so as to prevent overestimated results and achievement ratios.

Two recommendations are intended for ESTHER/EF or a similar future contractor:

1) The ESOPE patient management system should be reassessed, depending on the focus, whether clinical management or programmatic monitoring. As a comprehensive PLHIV database, it contains a wealth of information about HIV case management, including long-term follow-up, which can be used for clinical epidemiology or research purposes, provided it is up to date. It is not *per se* a tool for programme epidemiology or management. Since ESOPE cannot provide data for programme management, a parallel system has to be set up to document programmatic indicators. Any programmatic monitoring system must be simple and user-friendly.

2) The exit strategy should be a component of any large project, to prevent realisations from crumbling soon after financial support expires. Most vulnerable are the non-government

[3] The software ESOPE was developed in 2002 by a French private company to answer the needs of ARV treatment centres supported by ESTHER for computerised management of PLHIV's medical records. Individual records contain mainly clinical information (clinical picture, biology, treatment, adverse effects, follow-up, etc.) Automated reports can be produced for clinicians and programme managers. Data can be exported for additional statistical analysis.

staff receiving compensation directly from the project. The contractor should make sure that staff remaining necessary for interventions after the end of the project get sponsored by another donor, with as short a handover/takeover period as possible.

1. Background

In the early 2000, as a consequence of efforts by non-governmental organisations like the Treatment Action Campaign (TAC) in South Africa to obtain significant price reductions from pharmaceutical companies to increase the availability of generic 1st line ARVs produced mainly by Indian companies, prices for these medicines on the international market dropped considerably within a couple of years. Combined antiretroviral treatments that had only been accessible to AIDS patients in developed countries, became progressively available to millions of patients in the rest of the World and in particular in sub-Saharan Africa.

As the international community saw the urgent need for addressing the HIV/AIDS epidemic on a large scale to make visible progress, new organisations were set-up so to effectively and efficiently address the control of HIV/AIDS. The Global Fund was established in early 2002, practically at the same time as ESTHER.

In complement, UNITAID was established in 2006, with the mandate, among others, to contribute to the scale-up of access to treatment of HIV/AIDS, Tuberculosis (TB) and malaria by purchasing quality medicines, diagnostics and related consumable at negotiated rates. UNITAID works at an international level and locally through partner organisations in beneficiary countries, providing them with the necessary goods, while ensuring that goods ultimately reach the patients in need for these treatments. UNITAID has been playing a key role in the fight against HIV/AIDS, TB and malaria. As a consequence of efforts implemented at global level, about 15 million people living with HIV have access to antiretroviral treatment at substantial price reductions.

Since 2007, UNITAID and ESTHER explored the possibility of building a partnership. In five African countries - Benin, Burkina Faso, CAR, Cameroon and Mali – where ESTHER already had a long-time standing presence, it had been observed that both availability and usage of paediatric and second-line ARV drugs at treatment centres remained limited because of 1) the ARV management system was deficient; 2) quantifications and forecasts were not properly established; and 3) the demand for paediatric and second-line ARVs was low and/or irregular as diagnostic and monitoring tools of PLHIV were deficient. In 2008, ESTHER conducted a series of exploratory missions in these five countries so to address these challenges.

ESTHER submitted a new project proposal under the name “ESTHERAID” and submitted it to UNITAID. The proposal was then approved by UNITAID’s Executive Board in July 2008.

During 2009 and 2010 the first phase of the project consisted of a baseline assessment in each country, followed by discussions on the management of the project between the Government sector, ESTHER and other technical and financial partners such as WHO, UNICEF, UNAIDS, UNFPA, Clinton Health Access Initiative (CHAI), Management Sciences for Health (MSH)[4], Plan International, Solthis (in Mali), etc. Based on the results of the initial assessments, a careful planning of activities was developed in and for each country. In

[4] WHO provided technical guidelines and contributed to the development of various technical standards. UNICEF and UNFPA contributed to the support of PMTCT in the project countries. UNAIDS provided the overall picture of HIV/AIDS in the project countries and was involved in the collection of AIDS medicines and diagnostics service indicators. MSH implemented the USAID-funded ‘Systems for Improved Access to Pharmaceuticals and Services’ (SIAPS) Program in Cameroon and in Mali, etc.

December 2010, a MoU was signed between UNITAID and ESTHER, paving the way for the Phase 2 project implementation, which started in 2011 in the five project countries.

The goal of the project was to increase the number of patients enrolled and benefiting from paediatric and/or second-line ARVs in five countries Benin, Burkina Faso, CAR, Cameroon and Mali.

The focus of this initiative relied on the deficiencies outline above and as consequence the project had the following 3 objectives:

1) Improving the supply, storage and distribution management system from central to regional to peripheral level to treatment facilities;

2) Improving diagnosis and monitoring of PLHIV in need for paediatric and/or second-line ARVs by strengthening health care providers' technical capacities; and

3) Improving the ARVs quantification and forecasting methods with databases for patients and commodities.

The objectives were then translated into outputs which were formulated as follows:

- Output 1: Improved Procurement and Supply Management systems, i.e. "*the right drug at the right place at the right time*"
- Output 2: Optimized identification, treatment and monitoring of patients in need of paediatric and second-line ARVs at treatment facilities, i.e. "the right drug for the patient"
- Output 3: Improved measurement of ARV drug use and needs through drug inventory and patient monitoring systems at treatment facilities

From the negotiations between ESTHER and UNITAID about the project structure, the following aspects are of relevance as they strongly influenced the project implementation:

1) UNITAID expressed its interest to limit the duration of the funding to three years, from 2011 to 2013, a short time indeed for such a significant project.

This was then however reviewed in 2013 and one-year no cost extension was requested by ESTHER and approved by UNITAID. Thus the project duration was extended until the end of 2014.

2) UNITAID wished to invest over US$ 14 million into the Project, resulting in ESTHER implementing it in a total of five countries to ensure sufficient absorption of funds[5].

3) The Project emphasized capacity building measures at the government health sector level. No commodities were to be purchased by ESTHERAID. Medicines, reagents and other commodities were to be purchased by the government or by other projects/programmes.

It should also be noted that discussions between ESTHER and national health authorities lead CAR to focus country level activities on treatment access for paediatric patients, leaving aside second-line antiretroviral therapy (ART). Conversely, similar discussions in Burkina Faso lead the country to focus interventions on second-line ARV treatment, leaving aside the

[5] Personal communication when meeting with former ESTHERAID staff at Expertise France offices in Paris, 24-25 Feb16.

paediatric component. The country plans of the remaining three countries addressed both components**.**

2. Objectives of this evaluation

The main objective of the evaluation was to "provide UNITAID with an assessment of the programmatic implementation of the ESTHERAID project with a particular focus on the project's overall impact on the health system." The Terms of Reference (ToR) indicated that "specifically, the evaluation [would] review the overall goals of the project, its outputs and the activities for each output against questions related with the Relevance, Effectiveness, Efficiency, Impact and Lessons Learned…" (see ToR in Annex 1).

As a reminder, Annex 2 shows the project goal, outcome, the three 'generic' outputs, as well as the slightly modified versions to suit each country's plan and log frame.

The report also includes a limited analysis of the project's sustainability, i.e. of today's performance of activities originally strengthened by the project, until it closed down. (ESTHERAID formally ended in December 2014, but field activities already stopped at the end of September 2014).

3. Evaluation methodology

Two preliminary remarks have to be made before moving to the evaluation:

1) Being no audit, this evaluation accepted as such the results reported in the consecutive annual reports, e.g. number of local staff trained, number of laboratory tests or supervision visits carried out, etc.

2) The ToR of this evaluation did not include any comprehensive review of the financial component of the project. As a result, the report contains no section on the cost-effectiveness of activities.

As part of the evaluation approach, it has been agreed between Swiss TPH and UNITAID that the Swiss TPH team would meet with project coordinators at Expertise France in Paris, before conducting two one-week field visits to CAR and Cameroon.

The evaluation was conducted along the following 4 steps:

Step 1:

In February 2016, UNITAID made the essential project documentation available electronically to the evaluation team.

Among them were the following key documents:
1. Grant Agreement and Annexes including the project plan and logical framework
2. Inception report, annual and semi-annual reports of the project
3. MoU with countries
4. Mid-term evaluation report

5. Study on ESTHERAID project's sustainability and success factors
6. ESTHERAID Exit Strategy

Annex 3 provides a complete list of documents reviewed during the evaluation.

The evaluation team prepared an inception report for UNITAID with an outline of the evaluation process as well as a list of key questions for the meeting with ESTHER/EF on 24 and 25 February 2016. The team met with ESTHER/EF in Paris as planned; interviewed key staff involved in the ESTHERAID project and collected additional documents about the project.

Step 2:
Identification of some of the key informants in Cameroon and CAR recommended by ESTHER/EF during the meeting in Paris, and preparation of country visits.

CAR and Cameroon were selected for the following reasons:
- Cameroon, for having the largest cohort of patients under ART among the five countries;
- CAR, despite the relatively small cohort of patients, for having experienced the most challenging environment of the five countries during the project implementation period.

Step 3:
The evaluation team travelled to Yaoundé/Cameroon and Bangui/CAR to conduct face-to-face interviews with key informants and to visit a sample of treatment sites as well as central and peripheral warehouses. The visits took place from 27 February to 04 March 2016 in Cameroon and from 12 to 22 March 2016 in CAR. Based on recommendations from the two ESTHER/EF coordinators in Yaoundé and Bangui, the team met with key national decision makers at the MoH and the Central Procurement Agency, mostly with professionals directly involved in the project (see Annex 4 for the list of people met).

Step 4:
The last step consisted of preparing the report. This final draft included findings, recommendations and lessons learned for UNITAID to review. After UNITAID feedback on the draft, the report will be finalized and submitted to UNITAID for sharing with interested parties.

4. Findings

4.1. Relevance

Question 1: Did the goal and outcome, as indicated in the logframe, align with UNITAID's mission to contribute to the scale-up of innovations for treatment of HIV/AIDS?

The extended planning phase of the project, which included field evaluation missions in all five participating countries, assured that individual country project plans and budgets would correspond to the needs expressed by national stakeholders within the project objectives already outlined by UNITAID. To proceed towards project implementation, ESTHER had to submit all outcomes of this Phase 1 planning phase (country work plans, budgets, log frames) to UNITAID for their review and approval. The actual project implementation master

plan (called “Phase 2”) was agreed upon and documented in December 2010 in a MoU between UNITAID and ESTHER.

This careful and detailed but lengthier than expected planning phase assured that the ESTHERAID project activities corresponded to national needs, and enabled UNITAID to verify that activities for the defined objectives and outputs were fully respecting the UNITAID mission. Thus it can be considered that the ESTHERAID project remained relevant within the UNITAID mission framework.
UNITAID’s mission is to contribute to scaling-up treatment access to ARVs by providing quality products to governments over the long run and at accessible prices. In other words, UNITAID acts on the supply side of the market forces.

The ESTHERAID project in five African countries aimed to increase the number of patients receiving paediatric and / or 2nd line treatments by strengthening 1) the in-country supply and management system of ARV medicines and other commodities and 2) the health care system in charge of HIV/AIDS patients.
Through all three objectives (expressed as outputs in the log frame), the project boosted the supply for paediatric and 2nd line ARVs, by strengthening the various components of HIV/AIDS case management.

UNITAID and ESTHERAID were complementary. In this project, treatment access had to be seen in its broadest definition, encompassing low price purchase on the international market, supply of quality products, and quality of prescription, i.e. *the right drug at the right time for the right patient*.

In 2009, operating mainly as a large scale procurement organization, UNITAID was already funding paediatric and 2nd line ARVs in the five selected countries, when the ESTHERAID project started being planned. With its overall strategy changing over time – as reflected in the Strategic Plans 2010-2012 and 2013-2016 – UNITAID moved from focussing on direct procurement to market transformation activities, in order to increase access to paediatric and 2nd line ARVs by supporting approaches leading to decreasing prices and better products.
In line with UNITAID, the ESTHERAID project moved beyond the simple provision of medicines and commodities, to a more complete package of health care, including case management of patients, supply chain management, and training of health care staff.

Question 2: Did the goal and outcome align with the global response (and global health actors) to HIV/AIDS treatment?

From the early 2000s onwards, ARV price reductions have made AIDS treatment increasingly accessible to PLHIV in the developing world. At the same time, research findings have demonstrated the merits on life expectancy of starting ART before the patient’s immunity was severely damaged by the virus. From a CD4 cell count of 250 per ml originally, the World Health Organisation (WHO) guidelines recommended raising the treatment threshold to 350 CD4, then to 500 CD4 per ml[6], thus increasing the number of HIV patients to be enrolled in treatment. While clearly beneficiary to patients, these measures have resulted in ever growing needs for antiretrovirals. Over time treatment regimens have

[6] WHO. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. WHO. Geneva, June 2013.

become more acceptable, with various medicines combined into single pills, products with the severest side-effects (such as Stavudine) phased out of the market, and newer and better tolerable drugs such as Tenofovir becoming cheaper and more widely available.

Moreover, recent research findings have confirmed the role of 'treatment as prevention' in discordant couples and other vulnerable populations[7]. Without neglecting the numerous prevention interventions, efforts to promote and widen access to ARVs is plainly justified. By strengthening access to drugs by treatment centres in countries known for their weak procurement and supply management systems, and raising the quality of care for paediatric patients and those in need for 2nd line drugs, the ESTHERAID project was clearly in line with the global response to HIV/AIDS treatment.

4.2. Effectiveness

> Question 3: Were the outputs in the log frame achieved? Were the activities achieved?
> Question 4: What were the main factors influencing or preventing the achievement of the outputs?

The log frame presentation was based on the three project outputs formulated Annex 2. Each national work plan listed activities and sub-activities to fulfil the outputs. Likewise, indicators were defined, together with baselines and targets. Annex 5 shows the seven output indicators with essential information for each.

Each output performance was measured by at least two indicators. Tables 1, 2 and 3 show each indicator's performance based on the results reported in ESTHERAID's Annual Report 2014, in which results as reported per individual country. However, in its presentation of the project in the Annual Report 2014, UNITAID showed single achievement ratios per indicator. Therefore the evaluation team adopted the same approach in tables 1, 2 and 3.

Tables 4 to 6 will show the data separated per country, in the same way as ESTHERAID's Annual Report 2014.

[7] WHO. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. Geneva, July 2014.

Table 1: Global target, result and achievement ratio for indicators O1.1 and O1.2

Output 1: Improved PSM systems from Central Medical Stores (CMS)/warehouses to the selected Treatment and Counseling Centers (TCCs) by applying ARV management tools in decision-taking, supply quality assurance and storage procedures			
Indicator O1.1: Duration of stock-out for each designated tracer ARV at treatment care center level			
End of Project Target, per country (Sep14)	**Global Target (Sep14)**	**Per-country results (Jan – Sep 2014)**	**Global Achievement Ratio (Jan – Sep14)**
Benin : 0 Burkina Faso : 0 CAR : 0 Cameroon : 0 Mali : 0	No or 0 stock-outs	Stock-outs: No numbers provided. Yes for stock outs in Benin, Cameroon and Mali, No stock outs in Burkina Faso and CAR	(no achievement ratio)
Indicator O1.2: Number of people trained on Standard Operating Procedures (SOPs) related to PSM system			
End of Project Target, per country (2011 – Sep14)	**Global Target (2011 – Sep14)**	**Per-country results (2011 – Sep 2014)**	**Global Achievement Ratio (2011 – Sep14)**
Benin : 102 Burkina Faso : 173 CAR : 72 Cameroon : 415 Mali : 292	1039	Benin : 228 Burkina Faso : 357 CAR : 184 Cameroon : 249 Mali : 237 **TOTAL: 1255**	121%

Explanatory notes:
End of project target = target per country for the whole project duration (Jan. 2011 – Sep. 2014)
Global target = total of per-country targets
Achievement ratio = reported result divided by the corresponding target, in percent

Results for indicator O1.1 stock-outs are difficult to interpret. For each country and over the entire project duration, the target was zero stock-outs, i.e. the project aimed at not reporting a single day of stock-out over the 3 ¾ years of the project, an overambitious target indeed. It was also poorly defined. No information was provided about whether a stock-out should be considered in case a missing tracer ARV could be replaced by another product without adverse consequences for patients. For instance, at one treatment centre in Benin with a 75-day stock-out of Atazanavir/Ritonavir, the patient was put on the equivalent Lopinavir/Ritonavir, without adverse consequences being reported[8]. Whether the situation qualified as a genuine stock-out is debatable.

In the New Indicator Reporting Template attached to the First Amendment for a No-Cost Extension signed in July 2013, the definition of Indicator O1.1 is: *"Duration of stock-out for each designated tracer ARV at treatment centre level (with number of days, explanation and action taken if available)"*. Data entered in the ESTHERAID Reporting Template 2014 show exactly this. A review of the template confirmed the existence of significant stock-outs in Cameroon and Mali. In the case of Benin, however, missing tracer ARVs were replaced with others. Since no Reporting Templates for this Indicator were available for the previous years,

[8] Finding extracted from the ESTHERAID Reporting Template for 2014 for Indicator O1.1.

the evaluation team could not assess whether any progress was achieved from 2011 to 2014, i.e. fewer tracer ARVs missing during fewer days in fewer treatment centres.

Generally speaking, data generated by the indicator O1.1 could still have been exploited not only to document the performance of the project but also on a wider scale for the regular reporting mechanism, in order to better understand the consequences of stock-outs (for example treatment interruptions, or delays in starting ART, or forced treatment changes) or maybe the lack of consequences thanks to adequate solutions being identified to mitigate the stock-out situations).

Regarding the selection of tracer items to monitor stock-outs, the evaluation team notes that tracers included only ARVs, without considering any testing reagent. How large the role of reagent availability was on project performance ("Optimized identification, treatment and monitoring of patients needing paediatric and second-line ARVs in the selected TCC") has remained undocumented.

The ESTHERAID Annual Report 2014 just presented results as dichotomous: yes/no. The table in the annual report did not either specify whether results corresponded to 2014 alone or to the entire project duration. It is a pity that such a critical indicator was not better exploited by ESTHER over the course of the project.

Regarding the indicator O1.2 in the same table, the achievement ratio surpassed 100%, demonstrating that the results for the training in PSM exceeded the cumulative target set at the beginning of the project.

The explanation provided by ESTHERAID was that several government sector health facilities or Non-Governmental Organisations not directly associated with the project requested having their own staff trained with those of the project. With approval from UNITAID, ESTHERAID accepted the requests provided all project participants had already received training and that the cost would be borne by guest participants. As a consequence, some results are inflated without training budget being affected[9].

[9] Personal communication by former ESTHERAID staff based at Expertise France offices in Paris.

Table 2: Global target, result and achievement ratio for indicators O2.1 and O2.2

Output 2: Optimized identification, treatment and monitoring of patients needing paediatric and 2nd line ARVs in the selected TCC			
Indicator O2.1: Number of CD4 and Polymerase Chain Reaction (PCR) HIV tests (VL monitoring or Early Infant Diagnosis) performed			
Target per country over 9 mo. (Jan-Sep14)	**Project Target (Jan-Sep14)**	**Testing results and achievement ratios, per country (Jan-Sep14)**	**Project Achievement ratios (Jan-Sep14)**
For individual country results: see Table 5	CD4 = 52'500 (all) VL = 33'750 (without CAR) EID = 1125 (CAR only)	For individual country results: see Table 5	CD4 = 117% (all) VL = 32% (without CAR) EID = 85% (CAR only)
Indicator O2.2: Number of people trained on optimization of care offer			
End of Project Target, per country (2011 – Sep14)	**Global Target (2011 – Sep14)**	**Per-country results (2011 – Sep 2014)**	**Global Achievement Ratio (2011 – Sep14)**
Benin : 924 Burkina Faso : 1175 CAR : 383 Cameroon : 759 Mali : 561	3666	Benin : 1160 Burkina Faso : 1094 CAR : 832 Cameroon : 679 Mali : 588 **TOTAL: 4353**	119%

Explanatory notes:
Targets and results for O2.1 based on 2014 data (end of project target not specified)
Target and results for O2.2 based on data of the whole project
End of project target = target per country for January 2011 – Sep 2014
Global target = total of per-country targets
Achievement ratio = reported result divided by the corresponding target, in percent

Global results and achievement ratios for laboratory tests are good for CD4 counts, poor for Viral Load (VL) and acceptable for Early Infant Diagnosis (EID) in CAR (HIV detection in dried blood spots). For viral load tests, the global achievement ratio of 32% indicates that only one-third of planned tests were performed over the first nine months of 2014. Additional comments are made below when country data are considered separately.

The value of achievement ratio for indicator O2.2 is explained in the same way as for indicator O1.2: the global result obtained from data shown in the Annual Report 2014 surpassed the corresponding global target. More people were trained in HIV case management than anticipated at the beginning of the project in 2011 as non-project staff joined the training workshops with external financial support. Non project participants were accepted only if project staff had already received training.

Table 3: Global target, result and achievement ratio for indicators O3.1 and O3.2 and O3.3

Output 3: Improved ARV stock inventory information systems and patient monitoring systems in the selected TCC			
End of Project Target, per country (2011 – Sep14)	**Project Target (2011 – Sep14)**	**Per-country results (2011 – Sep 2014) (ESTHERAID - Annual Report 2014)**	**Project Achievement Ratio (2011 – Sep14)**
Indicator O3.1: Number of sites with patient monitoring tool			
Benin : 10 Burkina Faso : 8 CAR : 11 Cameroon : 13 Mali : 15	57	Benin : 10 Burkina Faso : 8 CAR : 9 Cameroon : 13 Mali : 15 **TOTAL: 55**	96%
Indicator O3.2: Number of sites with stock management tool			
Benin : 10 Burkina Faso : 8 CAR : 11 Cameroon : 13 Mali : 15	57	Benin : 10 Burkina Faso : 8 CAR : 9 Cameroon : 13 Mali : 15 **TOTAL: 57**	100%
Indicator O3.3: Number of people trained in data information system			
Benin : 125 Burkina Faso : 140 CAR : 103 Cameroon : 210 Mali : 307	885	Benin : 203 (target adjusted to 150) Burkina Faso : 216 CAR : 309 Cameroon : 248 Mali : 332 **TOTAL: 1308**	148%

Explanatory notes:
End of project target = target per country for January 2011 – Sep 2014
Global target = total of per-country targets
Achievement ratio = reported result divided by the corresponding target, in percent
Patient monitoring tool = standard patient record + (computerized or paper-based) data collection system
Stock management tool = (computerised or paper-based) data collection system

The project's results and achievement ratios were very good for the three indicators corresponding to Output 3, suggesting that the project's performance was smooth when in control of the necessary inputs. The poorer results obtained for VL testing and for ARV stock-outs may be explained by the fact that the project did not control all necessary inputs. However, without firm evidence this remains very much a hypothesis.

The project's results and achievement ratios obtained for the five indicators related with training and set up of management tools seem to confirm the effectiveness demonstrated by the implementation of the ESTHERAID project activities. The evaluation team had a positive impression of the project's achievements during the field visits in Cameroon and CAR, while

being aware that they were visiting just three sites over one week in each country, with limited time to delve into any hard data[10].

UNITAID reported two of the best results and achievement ratios in its final analysis of the ESTHERAID grant, shown in its Annual Report 2014, as evidence of market achievements in grants ending for 2014:

1) Number of sites with patient monitoring tool, with 96% achievement (55/57);
2) Number of sites with stock management tool, with 100% achievement (57/57).

UNITAID took the average value among the two percentages, stating that the ESTHERAID grant has achieved its "market target" by 98%.

Tables 4 to 6 present the same data as tables 1 to 3, but separated by country and analysed as such.

Table 4: Targets, results and achievement ratios for indicators O1.1 and O1.2

Output 1: Improved PSM systems from CMS/warehouses to the selected TCCs by applying ARV management tools in decision-taking, supply quality assurance and storage procedures			
Country	**End of project target**	**Results (2011 - Sept 2014)**	**Achievement ratio**
Indicator O1.1: Duration of stock-out for each designated tracer ARV at TCC level			
No additional information compared with table 1.			
Indicator O1.2: Number of people trained on SOPs related to PSM system			
Benin	102	228	224%
Burkina Faso	173	357	206%
CAR	72	184	256%
Cameroon	415	249	60%
Mali	292	237	81%

While the data used to construct the table are the same as in table 1, the achievements ratios per country point to striking differences across countries. While the mean percentage was 121%, country values extend from 60% to 256%. Lower values for Cameroon and Mali were explained in the Annual Report 2014 by the cancellation of some training activities.

Although no comment was written down in the report, the team was given the same explanation as for table 1 for higher than expected results: non project participants attending the training workshops with external financial support. The above-100% achievement ratios in Benin, Burkina Faso and CAR point to the fact that all targeted project staff were trained. The surplus was the result of non-project staff being trained. The below-100% values for Cameroon and Mali were the consequence of not all project staff receiving training. No outsiders were included in these training sessions.

[10] The team's 'positive impression' was based on numerous accounts by former project staff (doctors, nurses, laboratory staff, pharmacists, community workers, data managers) of the benefits of having attended one or more workshops or short courses in-country or abroad.

Table 5: Country targets, results and achievement ratios for indicators O2.1 and O2.2

Output 2: Optimised identification, treatment and monitoring of patients needing paediatric and 2nd line ARVs in the selected TCC			
Indicator O2.1: Number of CD4 and PCR HIV (VL monitoring or EID) performed			
Targets, testing results and achievement ratios, per country (Jan-Sep14)			
Benin : CD4 = 10287 / 11250 = 91% VL = 2881 / 7500 = 38%		Cameroon : CD4 = 30284 / 22500 = 134% VL = 211 / 15000 = 14%	
Burkina Faso : CD4 = 9382 / 7500 = 125.1% VL = 3542 / 3750 = 94%		Mali : CD4 = 10794 / 9000 = 119% VL = 2285 / 7500 = 30%	
CAR : CD4 = 1065 / 2250 = 47% EID = 961 / 1125 = 85%			
Indicator O2.2: Number of people trained on optimization of care offer			
Country	**End of project target**	**Results (2011 - Sept 2014)**	**Achievement ratio**
Benin	924	1160	126%
Burkina Faso	1175	1094	93%
CAR	383	832	217%
Cameroon	759	679	89%
Mali	561	588	105%

For Indicator O2.1 results and achievement ratios show notable differences across the five countries. Achievement ratios for CD4 counts are good to very good in four countries. Only CAR's performance is lower. No explanation was provided with the table in the Annual report 2014.

Per-country achievement ratios for VL vary from 14% (Cameroon) to 30% (Mali) to 38% (Benin) to 94% (Burkina Faso). Still, in Benin the number of tests in 2914 was nearly twice as much as in 2013. Mali was said in the Annual Report 2014 to have suffered from stock-outs of reagents and consumable. No explanation was given for Cameroon, except for missing data from two treatment centres.

When data of the four years were analysed (not shown here), it was noted that the number of tests went gradually upwards in Benin and Cameroon, even though the achievement ratios for 2014 were just 38% and 14% respectively. In Burkina Faso and Mali, the number of tests went up and down between 2011 and 2014, suggesting that shortages of reagents and/or defective equipment could have affected the performance in those two countries. The 2014 Report does indeed refer briefly to reagent stock-outs in Mali, but offers no explanation for Burkina Faso.

For indicator O2.2, individual country values vary widely. The same explanation was provided by ESTHER/EF as for the indicator O1.2.

Table 6: Country targets, results and achievement ratios for indicators O3.1, O3.2 and O3.3

Output 3: Improved ARV stock inventory information systems and patient monitoring systems in the selected TCC			
Country	**Target per country (2011 - Sept 2014)**	**Results per country (2011 - Sept 2014)**	**Achievement ratio**
Indicator O3.1: Number of sites with patient monitoring tool			
No additional information for this indicator compared with table 3			
Indicator O3.2: Number of sites with stock management tool			
No additional information for this indicator compared with table 3			
Indicator O3.3: Number of people trained on data information system			
Benin	150	203	135%
Burkina Faso	140	216	154%
CAR	103	309	300%
Cameroon	210	248	118%
Mali	307	332	108%

Again, results per country for indicator O3.3 vary significantly. The Annual Report 2014 did not provide any explanation in writing, but upon request from the evaluation team the former project staff based at EF offices in Paris provided the same explanation as reported above for O1.2.

In order to analyse the rate of realisation of project activities in each country, the evaluation team constructed tables showing, for each country and output, the list of planned activities extracted from the log frames and operational plans, as well as the corresponding realisations, extracted from the annual reports since the start of the project. These tables can be found in Annexes 6. Cells highlighted in colour (for our identification) describe planned actions that seem to have been incompletely carried out or not at all. Out of a total of 61 activities in the five countries (each one divided in several subactivities), eight to ten were probably incomplete or undone, yielding an estimate of 13 to 16% of activities incomplete or undone. Our findings are in line with the statement in the final report that by end September 2014, 85% of planned actions over the entire project life had been successfully completed.
This was very much a semi-quantitative exercise, since activities are not units of the same size. Some activities were more complex or included a larger number of subactivities than others.

The annual reports indicated that planned actions with the software Medistock in Benin and Cameroon were cancelled, because of ongoing problems and delays of the software development. Three activities planned in CAR had to be cancelled for security reasons, after March 2013 coup d'état and the political unrest persisting up to 2015.

4.3. Efficiency

Question 5: Were the outputs and activities completed according to the project timeline and budget?

Table 7: Annual expenditure, real or estimated vs. the total budget

		BUDGET MoU	Expenditures in 2011	Expenditures in 2012	Budget for 2013	Budget for 2014 (NCE)	TOTAL
GLO-BAL	Activities five countries	8'471'383 €	278'871 €	1'424'001 €	3'991'634 €	2'104'034 €	7'798'540 €
	Local Administration	1'471'252 €	333'742 €	439'413 €	481'590 €	454'590 €	1'709'335 €
	HQ Administration	1'415'168 €	370'041 €	394'111 €	481'300 €	549'632 €	1'795'084 €
	Final Project Evaluation	500'000 €	0 €	0 €	500'000 €	0 €	500'000 €
	TOTAL	11'857'803 €	982'654 €	2'257'525 €	5'454'524 €	3'108'256 €	11'802'959 €

OVERALL BALANCE:	54'844 €

Table 7 above shows the project budget after the request for No Cost Extension had been approved by UNITAID in July 2013, with a global view of the whole course of the project. Please note that the years 2011 and 2012 show actual expenditure, whereas the years 2013 and 2014 still show the estimated budget[11]. It can be reasonably assumed that by the end of the project, expenses remained within the limits of the overall budget.

The table also shows that activities in the five countries picked up strength over the four years. The lower figure in 2014 is partially explained by the fact that activities ended in September.

Being ESTHERAID Phase 2's starting year, 2011 saw fewer activities than the following years. In fact, between delays caused by the signature of each MoU (between October 2010 and July 2011), the installation of local offices and recruitment of project staff, realisations and expenditure in the first two years were modest, as shown in the table below (adapted from the final report of the Mid-Term Evaluation). By the end of the second year, i.e. after two-thirds of the initial duration of the Project, the overall expenditure was still well below 50% of the three-year projected budget. Based on these findings, made at the time of the mid-term evaluation, it was decided that ESTHER would submit a request to UNITAID for a no-cost extension.

[11] The financial component of the project being excluded from this evaluation exercise, the team worked mainly on annexes provided with the No Cost Extension Amendment.

Table 8: Percent of activity realisation and expenditure after two years[12]

Country	Activities realised after 1 year (%)	Activities realised after 2 years (%)	Expenditure after 2 years (%)
Benin	26	50	40
B Faso	19	55	45
Cameroon	2	25	30
CAR	5	30	20
Mali	0	30	13

Activities realised after one and two years are compared with activities initially planned over the three years of ESTHERAID Phase 2.
Likewise, expenditure after two years is compared with the projected budget over three years.

Please note that despite being expressed in percent, activities and expenditure shown in table 8 cannot be readily summed up, because they are not identical across countries.

By the end of the no-cost extension, 85% of activities had been completed (ESTHERAID annual report 2014), with some differences across individual countries, partly because of the political context (military intervention in Mali in 2012; political unrest in CAR between March 2013 and early 2015.)

The financial information encountered in documents made available to the team helped draw the following table 9.

Table 9: Unspent budget by September 2014, per country

Country	Initial budget as per MoU(1)	Expenditure by September 2014(2)	Expenditure execution rate (%)
Benin	1'980'275 €	1’753’311 €	88.5%
B Faso	2'002'398 €	2’069’115 €	103.3%
Cameroon	1'917'343 €	1’531’834 €	79.9%
CAR	2'026'138 €	1’777’103 €	87.7%
Mali	2'016'481 €	1’624’077 €	80.5%

(1) Initial budget per country found in the final budget submitted with the 2013 request for no-cost extension.
(2) Expenditure per country reported in ESTHERAID’s Annual Report 2014.

The country budget covered expenses in-country, i.e. field activities and local administration, excluding expenses of ESTHER’s head office in Paris. By September 2014, when field activities stopped, Burkina Faso had slightly overspent; Benin and CAR had around 12% of their budget left, but Cameroon and Mali had still about 20% of their budget unspent. Cameroon was said to have underspent partly because of the delayed start of the project in 2011. Mali’s underspending was explained by the political unrest following the coup d’état in March 2012 and by the French military intervention in 2013 rendering access to regions of

[12] Data extracted from a table in the Mid-Term Evaluation Report of the ESTHERAID Project.

the country impossible[13]. For each country, part of the remainder was still used to cover local administrative expenditure until the end of 2014.

4.4. Impact

Question 6: Did the Project result in the intended impact?

In the project log frame, Goal or Impact was defined as "to contribute to increasing the number of patients accessing paediatric and 2nd line ARVs in selected treatment centres." Two indicators were set to measure the project's impact: the number of children under ART and the number of adults and children under 2nd line ART, as shown in table 10.

Table 10: Performance measured by Goal Indicators 1 and 2

	Indicator G1: # children under ART				**Indicator G2: # adults & children under 2L**			
Country	Baseline	Target	Sep 2014	Achieve-ment ratio	Baseline	Target	Sep 2014	Achieve-ment ratio
Benin	539	809	803	99%	365	730	544	75%
Burkina Faso					170	340	426	125%
Cameroon	1'101	1'652	1'748	106%	2'043	4'086	3'423	84%
C.A.R.	406	609	739	121%				
Mali	1'369	2'054	1'717	84%	2'117	4'234	2'140	51%
TOTAL 4 countries		5'124	5'007	**98%**		10'871	6'533	**60%**

Explanatory notes:
- Burkina Faso had no paediatric component, while C.A.R. had no 2nd line treatment intervention.
- Baseline G1: number of children under ART at the start of the Project in 2011; baseline G2: number of patients (adults and children) under second-line treatment before the start of the Project in 2011.
- Target: for indicator G1, baseline x 1.5; for indicator G2, baseline x 2.
- September 2014: number of subjects enrolled in paediatric or 2nd line treatment by the end of Project activities.
- Achievement ratio: actual result divided by corresponding target, in percent.

Achievement ratios indicate that the impact of the project, measured by these two indicators was reasonably good, in spite of the lack of ESTHERAID's direct influence on procurement and delivery of medicines and reagents. Mali's performance was lower than that of the remaining countries. The fact that the cohort of 2nd line ART patients of September 2014 includes only 23 additional persons (+ 1.1%) compared with the baseline is misrepresentative, following clarifications by ESTHER/EF. The baseline value was shown *a posteriori* to be overestimated because of the failure to clean the database of deceased and

[13] Personal communication by the former ESTHERAID staff at Expertise France offices in Paris.

lost-to-follow-up patients[14]. The corresponding target was overestimated accordingly. In Benin, Mali and in Cameroon, failure to reach the target for 2nd line ART patients was reported by ESTHERAID to be caused by the 'very limited access to viral load'. A review of the list of realisations vs. activities in the per-country tables in Annex 6 did not identify any other specific weakness.

It is interesting to note that for both indicators the best results were achieved by the two countries focusing on a single intervention, CAR respectively Burkina Faso.

Please note that in its annual report 2014, UNITAID presented the results of the two goal/impact indicators as two single achievement ratios: 98% and 60%. UNITAID then concluded that the ESTHERAID grant had reached no less than 79% of its "public health targets" as defined in the UNITAID IMPACT 2014 report.

The achievement ratios for the two goal indicators should however be tempered by the results of the *HIV retention rate*, another essential indicator of HIV treatment, care and support in general, defined as the "number and percent of adults and children with HIV, known to be on treatment 12 months after initiation of ART". Among PLHIV starting ART by end 2014 and monitored at the end of 2015 in Cameroon, the retention rate after 12 months was 64.7%. In CAR, the retention rate was 81.4%[15]. It would have been interesting to see whether any trend towards improvement was observed during the ESTHERAID project and beyond, but this indicator was not part of the project's log frame.

Additional data from CAR show that, in spite of ESTHERAID's efforts, CAR reached limited decentralisation between 2013 and 2015, as shown in the table below.

[14] Briefly mentioned in the Executive Summary of the Annual report 2014, pg. 8, and confirmed by ESTHER/EF staff.
[15] The Cameroon value was provided by ESTHER/EF local staff in Yaoundé. The CAR value was provided by the M&E officer at the DLES in Bangui.

Table 11: Number of children with ART at each treatment site in Bangui
Data from Monitoring and Evaluation (M&E) officer at Directorate for the fight against Specific Endemic Diseases (DLES)

Site name, in Bangui	Paediatric ART data 2013	Paediatric ART data 2014	Paediatric ART data 2015
1. Centre pédiatrique de Bangui	908	944	965
2. Hôpital Communautaire	0	1	8
3. Hôpital de l'Amitié	No data	No data	No data
4. Ouango health centre	0	3	0
5. Boy-Rabe health centre	0	19	23
6. Castors Health centre	0	0	9
7. Bédé-Combattant health centre	70	82	89
8. Begoua health centre	15	20	18
9. Maternité de la Gendarmerie	No data	No data	No data
Total in Bangui	993	1069	1112

Explanatory notes:
Bouali health centre and Mbaiki district hospital were no longer been reachable after the coup d'état in 2013
The "Maternité de la Gendarmerie" replaced Lakouanga health centre since the beginning

Apart from a modest increase in the number of children under ART at Boy-Rabe and Castors, the expected decentralisation had not yet been achieved by the end of 2015. However, account must be taken of the marked civil unrest between March 2013 and mid-2015 that resulted in populations fleeing the capital city, disrupting health interventions completely. As an anecdote, Begoua health centre got looted three times during that period.

Question 7: What could be the value for money of UNITAID's investment in this project?

Following UNITAID's investment of 11,802,959 EUR (of which 10'486'806 EUR were spent)[16] in the 2nd Phase of the project (2011–2014), ESTHER did a remarkable work of strengthening in-country capacities in the governmental sector along three outputs, 1) strengthening all elements of the PSM chain, 2) optimizing HIV case management of PLHIV needing paediatric or 2nd line ART, and 3) building up the clinical and pharmaceutical data collection and reporting system. The project sought to achieve all this by assisting in updating guidelines and standard operating procedures, by training large numbers of professionals of various categories (pharmacists, laboratory personnel, clinicians, community workers, data managers, etc.), by standardising patient records, dispensation records, and lots of other data collection tools, etc. Details can be found for each country in the extensive lists of planned and realised activities shown in Annex 6.

In a nutshell, value for money (VFM) is about documenting the balance between the "three E's" (economy, efficiency and effectiveness). A VFM analysis intends to compare the inputs of the project (the costs or the economy) with the output (efficiency) and how they contribute to the outcomes and impact (effectiveness). The analysis of the VFM of UNITAID's funding of the ESTHERAID project compares the costs with the achieved impact defined as "to contribute to increasing the number of patients accessing paediatric and 2nd line ARVs in selected treatment centres."
The main results are shown in the following table.

Table 12: Value for Money

Country	Total expenditure per country* (EUR)	New paediatric patients**	New 2L patients**	Total	Cost per patient (EUR)
Average 5 countries	1'902'310				(4'732)
Benin	1'868'688	264	179	443	4'218
Burkina Faso	2'220'067	N/A	256	256	8'672
Cameroon	1'944'934	647	1'380	2'027	960
CAR	1'690'741	333	N/A	333	5'077
Mali	1'787'121	348	23***	371	(4'817)

Explanatory notes:
(*) Per country expenditure includes all expenses related with activities, as well as costs of respective country office operation and an equal share of the main ESTHERAID office in Paris.
(**) In this table, new patient means any patient incorporated in the cohort at any time over the duration of the project (Jan 11 to Sep14).
(***) This number is known to be underestimated. ESTHERAID acknowledged that the baseline had been overestimated, as the database had not been cleaned of all invalid records.

[16] Source: ESTHERAID Financial Report 2014, shared by ESTHER/EF with the evaluation team in June 2016

Table 12 shows the value for money corresponding to the 2nd Phase of the project. To the actual expenses for activities carried out in each country between 2011 and 2014 were added the expenses of operating the project country office as well as an equal share of the expenses of the ESTHERAID office in Paris. The total per country was then divided by the total number of patients incorporated in the two cohorts (except in CAR and Burkina Faso where there was only one), resulting in a unit cost per patient.
It should be noted that separating costs between paediatric and 2nd-line patients was not feasible, since many activities contributed to strengthening of the case management of both categories of patient at the same time. It should also be noted that retention rates in the two cohorts being unknown during the project, they were not taken into account in the calculations. Finally, as the project had no budget line for commodities, they were clearly not taken into account in the calculations either.

The average cost per patient is 4'732 EUR (taking account of the approximate figure from Mali), but the range is wide, as shown by the lowest (960 EUR in Cameroon) and highest unit costs (8'672 EUR in Burkina Faso). Whereas the country levels of expenditure did not vary hugely (average expenditure by country + 17% in Burkina Faso; average - 11% in CAR), the number of newly incorporated patients did so strikingly, explaining the wide difference of cost per patient between these two countries.

In fact, this analysis provides an imperfect picture of the project VFM. Firstly, the two impact indicators used in the analysis capture only part of the project achievements. Strengthening pharmacists' capacities in estimating ARV needs, managing stocks and dispensing medicines to patients was most likely to contribute to health system strengthening in general. Training healthcare providers in HIV/AIDS case management was also likely to have strengthened their capacities in other aspects of HIV/AIDS case management. The data collection and reporting system the project developed for PLHIVs might have been used as a blueprint for other disease programmes. Since none of these aspects was measured by the project, results remain elusive.

Secondly, the project concentrated on in-country capacity building for HIV/AIDS case management, while relying on partner organisations for the procurement of ARVs and laboratory reagents. The project's inputs had to be made, regardless of the number of newly enrolled patients in each country. Fixed, as opposed to variable, these costs represented an investment by the project in each country. Had ARVs and laboratory reagents been more regularly available, the number of newly enrolled patients might have been significantly larger, for roughly the same inputs, resulting in a lower cost per patient.

Browsing through project reports in addition to talking to former project staff revealed the relative frequency of stock-outs of reagents or ARVs (not all of them simultaneously). For example, in 2011 and 2012 shortages of laboratory reagents impaired diagnostic activities in all countries[17]. In 2012 Benin also suffered from periodic stock-outs of some ARVs.
In Mali, the Global Fund's support to the national HIV/AIDS control programme was suspended from March 2011 until August 2013, after irregularities had been identified by the OIG.
In CAR, depending on the Global Fund for its supplies of ARVs and laboratory reagents, the national HIV programme was affected by a 2010 decision from the Global Fund to switch to Voluntary Pooled Procurement (VPP)[18] for all drug purchases, which created confusion among CMS's staff. In addition, insufficiencies in forecasting capacity led to chronic delays in

[17] Source: ESTHERAID Annual Report 2012, pg 5.
[18] Now named Pooled Procurement Mechanism (PPM)

procurement. As an anecdote, at the time of a visit by the Office of the Inspector General (OIG) in May-July 2012, stock-outs were reported to be continuous, paralysing programme activities[19].
It has to be acknowledged that ESTHER kept running activities as much as possible, despite local problems.

Should ESTHERAID have better anticipated the problem of recurrent stock-outs of laboratory reagents and ARVs?
Having already worked for several years in the five countries, ESTHERAID was aware of the existence of stock-outs at central or peripheral level because of local professionals' limited capacities. This is precisely why the strengthening of supply management was one of the three project's objectives. Strengthening reagent/medicine forecasting, stock management, timely distribution and storage was not going to occur in just a few months.

This being said, it might have been relevant to anticipate the risk of failure to procure reagents and ARVs at national level by establishing a partnership with organisations willing to make emergency deliveries of critical products. Initially it was expected that ESTHERAID would be complementary to the UNITAID-funded CHAI ARV programme, but, in 2011, this one was already winding down when the Phase 2 project started. Depending on external donors for procurement, among which the Global Fund, ESTHERAID's performance was directly affected by reagent/ARV shortages consecutive to decisions made by the Global Fund, particularly in Benin, CAR and Mali.

4.5 Sustainability

The evaluation team did explore this aspect by looking at the project's performance after the formal end in December 2014. Clearly, the results of capacity building activities during nearly four years had to persist over time.

Information about the three countries not visited was collected from key informants' answers to a simple questionnaire focusing specifically on the project's sustainability after 2014. Annex 7 shows the blank questionnaire e-mailed to a list of key informants and to the local EF coordinator in Burkina Faso. The list of informants had been prepared for the evaluation team by EF in Paris. Questions were prepared based on the list of activities carried out in 2014 in the three countries. Cameroon facts are based on visits to HIV treatment centres in three hospitals, all three with large cohorts of PLHIV, two in Yaoundé and one in Bafoussam. In the case of CAR, data derive from visits to the main paediatric hospital and treatment centre in Bangui, as well as to two sites at peripheral health centres.

Observations related to sustainability for the five countries are summarised in the table in annex 8. Answers for Benin, Burkina Faso and Mali should be considered as a poll rather than any sort of study. Responders were few and did not necessarily express consensual opinions. Still, they provided some valuable insights.

By the end of 2015, the number of children under ART had increased by nearly 3% in Benin, by 50% in CAR and 43% in Mali, compared with September 2014. In CAR, numbers were provided by the medical doctor in charge of the HIV M&E at the DLES during the team's visit.

[19] D. Garmaise. Audit of Grants to Central African Republic Highlights Difficulties of Operating in Challenging Environments. Global Fund Observer. 25 Feb 2013.

Data for second-line ART were more surprising, since both Benin and Burkina Faso reported slightly lower numbers than in September 2014: minus 57 PLHIV in Benin and minus 56 in Burkina. The differences might simply be explained by calculation mistakes, but there was no opportunity to further investigate. Mali reported a 30% increase of the number of PLHIV under 2nd-line treatment between September 2014 and December 2015.

Stock-outs kept affecting Mali and at least one site in Benin, but Benin and CAR did not undergo any ARV stock-out.

PSM and laboratory-related activities appeared not to have been significantly affected by the end of the project in any country, although at the three sites in Bangui, laboratory output was very limited.

Clinical case management appears to have been affected by healthcare providers, especially medical doctors, leaving their position in Benin, Burkina Faso and CAR. Burkina Faso saw recently lots of medical doctors walking away from the position when the Government made access to specialisation easier. Whatever the explanation, the "loss" of trained medical doctors is frustrating since many benefited from trainings and courses abroad, including in France, during the project. The case of CAR is particularly worrisome, since five out of the six professionals involved in the project had left their position at the time of evaluation team' visit. ESTHERAID probably bears no direct responsibility. Health care providers' attrition has been a recurrent problem in many projects, especially in the public sector, even without considering CAR's events over the past few years.

Community interventions and computerised patient data management appear to have suffered the most from the end of the project.

Despite not being government employees, and often with limited education, community workers play a valuable role at the interface between institutional care and the community at large, providing information and counselling to patients and families, organizing peer support groups, looking for lost to follow up patients, etc. In addition to benefiting from training sessions, many gained experience over years of working with the project[20]. The (modest) compensation received for their work with the project stopped in 2014. During 2015, the shortfall was alleviated by limited, short-term funding from other financial and technical partners, but no long-term solution has been found so far. Most community workers were expected to be paid for the same interventions by the Global Fund soon-to-start programmes, but at the time of the team's visit, payments had not yet materialised, discouraging workers, slowing down their efforts and putting the community component at risk of collapsing.

In the case of computerised patient data management, sustainability issues were reported in Benin, Cameroon and CAR, but not in Burkina or Mali. In Benin, data collection and reporting with ESOPE stopped completely after the end of the project, reportedly because of technical issues with computers and the lack of funding to pay for the data entry. In Cameroon, ESOPE was still functioning in the three hospitals-treatment centres visited by the team, yet was seriously under threat because of the operators no longer being paid since end 2015 (funding had still been available in 2015). In CAR, difficulties were caused by a mix of unpaid staff and technical problems with the software[21]. At the Centre Pédiatrique de Bangui, which

[20] Information provided to the team by ESTHER/EF local office staff in Cameroon and CAR.
[21] The local ESTHER/EF office staff in Bangui was informed at a final debriefing meeting.

attends a large cohort of children, about 40% of patients' records had not yet had their data entered into the system[22].

Formative supervisions were part of ESTHERAID's smart strategies to perpetuate capacity-building by training new staff on the job with assistance from more experienced professionals. However, the summary table shows that such supervision visits have been irregular or non-existent in Burkina, Cameroon and Mali since the end of the project, again because of the lack of funding. In contrast, CAR had managed to keep a limited number of supervision visits.

Finally, in Cameroon, the team was told that regular meetings of the ARV Procurement Coordination Committees (also called Platforms) had still occurred in 2015 as a result of additional resources coming from ESTHER, but no meeting had been held since the start of 2016 because of the lack of funding.

In conclusion, ESTHERAID interventions did altogether cease to exist after 2014. Most vulnerable were activities depending of staff receiving compensations directly from the project. In Cameroon and CAR, activities kept moving along thanks to additional funding from ESTHER/EF or other partners. In Mali, key informants reported that the government had taken the financial support over.

[22] Personal communication by the ESOPE data entry manager, Complexe Pédiatrique de Bangui.

5. Lessons learnt

Question 8: What lessons can UNITAID learn about funding this type of project?

1) The ESTHERAID Phase 2 project did a remarkable work within the limits established by the MoU signed between ESTHER and UNITAID in December 2010, according to which no resources would be allocated to the purchase of equipment, medicines and laboratory reagents (with exceptions for three sites in Benin, Burkina and CAR). UNITAID had no plans to fund any commodity on a large scale, parting from the standpoint that several other financial partners supported their procurement in the five countries. This approach was accepted by ESTHER as well as by many beneficiaries. A pharmacist holding a senior position in the MoH in Cameroon told the evaluation team: *"A project focused on strengthening all components of the pharmaceutical sector over several years was perceived as truly innovative."*

However, ESTHERAID might have obtained even better results if medicines and reagents had been more readily accessible. Stock-outs did affect the project repeatedly. When the evaluation team visited Cameroon and CAR, this issue raised heated discussions. Should prevention of stock-outs be assured only through capacity building, or should procurement complement capacity building interventions?

A stock-out of any commodity is rarely a quick and easy-to-fix situation. Most often it is a very complex situation with multiple partners being involved, in multiple activities and at various stages of the supply chain. The ESTHERAID project addressed these challenges with laudable efforts, various approaches and insistence of many actors highly committed to improving these problems. Nonetheless all five countries reported ARV stock-outs until the very end of the project implementation, thus leaving little indication that the problem would be durably fixed beyond the end of the project. Stock-outs of paediatric and 2nd line ARVs were expected to continue. This may represent a failure and a reputational problem for any project aiming precisely to prevent stock-outs.

2) In documenting the provision of services to PLHIV requiring paediatric or 2nd line ART, or to any other type of patient, principles and guidelines are global, but implementation is always local, complex and time-consuming. During Phase 1 of the project, ESTHER/EF spent a significant amount of time discussing and developing each country plan with government health authorities and numerous partners, along national strategies. The project aimed at actively supporting each country's government sector. It carried out an impressive array of activities to reach its three objectives/outputs shown in the log frame. During the visits in Cameroon and CAR, the evaluation team heard several interviewees commending ESTHERAID for its flexibility in responding to local problems.

Once a year, ESTHERAID staff was allowed by UNITAID to reprogram the budget within limits in a frequently changing context. For example, in some countries activities were cancelled and funds reallocated after another donor emerged with identical plans. Some of

the meetings and trainings were moved from CAR to neighbouring Cameroon after the 2013 coup d'état in CAR. Similarly, in Mali activities resumed after being reorganised following the events in 2012 and 2013.

3) Working in five countries concurrently resulted in slowing down progress because of inherent differences between countries. For example, administrative procedures took Cameroon nearly the whole year 2011 to start project implementation, whereas the other four began earlier. Burkina Faso is known to have a relatively stable political system and competent health personnel, whereas CAR has been suffering until recently from chronic political instability as well as a severe shortage of health care professionals, etc. To the evaluation team's opinion, the complexity of managing five countries was not sufficiently compensated by the advantage of sharing knowledge and experience.

Question 9: What can be learned about working in the project countries? What should UNITAID know before funding other projects in these countries?

1) Whereas principles and guidelines are global, implementation is local. Each country's operational plans were tailored to its own context and needs. In addition, the process of capacity-building is slower than procuring equipment and commodities to a country. UNITAID might consider implementing another similar project over a period of time longer than three years.

2) A project that solely builds capacities, without the necessary resources to procure equipment, medicines and laboratory reagents, either on its own or through a formal partnership with a commodity supplier, is threatened by shortages and/or stock-outs. Before the start of the project, it was anticipated that ESTHERAID would work closely within the project of CHAI that included ARV procurement (funded by UNITAID as well). However, by the time ESTHERAID started, the CHAI project was getting to an end. ESTHERAID expected other well-established donors (the Global Fund, the World Bank, etc.) would meet procurement needs. The fact that ESTHERAID was affected by repeated stock-outs shows that procurement was anything but smooth. In the past few years, at least three international organizations have set up or considered setting up emergency commodity stocks in West Africa[23] to provide limited quantities of products whenever planned procurements would be delayed. Whatever the focus, any future project should study the ways to minimise the risk of stock-out. This topic is further developed in the recommendations.

3) Health professionals leaving their position shortly after being trained and being replaced by newcomers unfamiliar with procedures are a regular occurrence in many developing countries. There is no simple fix to this problem. Developing reference and operation manuals and distributing them widely during the project was one of the solutions adopted by

[23] UNICEF. ARV emergency stock. http://www2.unicef.org:60090/supply/index_44364.html (published 11 Nov15); WAHO. ARV Drug Security in ECOWAS Member States (2013). http://wahooas.org/IMG/pdf/_Projet_stock_securite_.pdf. PEPFAR. PEPFAR HIV/AIDS Emergency Commodity Fund (no date). http://www.pepfar.gov/documents/organization/197230.pdf;

ESTHERAID. Having health professionals trained so as to organize retraining after the end of the project was another option. However, the lack of funding in some countries prevented retraining from occurring. Through other projects, ESTHERAID did secure limited funding to keep some activities going on after 2014, but most funding stopped after 2015.

Future projects should have their exit strategy fully spelled out in their operational plan, just like other activities. ESTHERAID did have a written exit strategy, published in June 2014. The introductory statement that the ESTHERAID project was “by nature sustainable” may be seen *a posteriori* as rather overoptimistic.

4) Key informants in Burkina Faso and in Mali reported that the ESOPE patient data management system was operating smoothly in Mali and satisfactorily in Burkina Faso. The evaluation team had a different perception in Cameroon and CAR, where financial issues and technical problems affected the system. Key informants in Benin reported a similar experience. Most of all, the system was significantly underused, except for one medical doctor at the Hôpital Central in Yaoundé. Although no decision was made at the time of our visit, the usefulness of the ESOPE system was being questioned by the MoH of Cameroon.

5) Even though it focused mainly on capacity building, the ESTHERAID project failed to include output indicators directly measuring the results of capacity building activities, such as pre/post training workshop knowledge tests, production of essential guidelines and procedures manuals, waiting time before having one‘s prescription filled, etc. Unlike the impact indicators that were affected by shortages/stock-outs of ARVs and reagents, results for these indicators would have directly documented project’s activities.

6. Recommendations

6.1 For UNITAID

1) For a future project focusing on capacity-building, i.e. a complex and time-consuming undertaking, UNITAID should consider extending the duration from three to five years. If duration cannot be lengthened, UNITAID should consider implementing it in a smaller number of countries than done five countries with ESTHERAID, to streamline and speed up management and coordination.

2) A future project similar to ESTHERAID should partner with an emergency commodity fund/stock to minimise the risk of stock-outs. Alternative options include setting up a specific emergency stock for the project, contributing to setting up a national emergency plan in each project country, or closely partnering with a procurement project such as the Global Fund.

3) A future project aiming at improving ARV accessibility by paediatric or second-line PLHIV through capacity-building should include the HIV retention rate indicator that complements the two indicators related with coverage of interventions.

4) UNITAID could have been more demanding from ESTHER/EF in terms of reporting some of the results in the final report 2014. Had ESTHER/EF exploited the stock-out data as indicated in the log frame, the indicator O1.1 would have yielded much more information than it did.

6.2 For ESTHER/Expertise-France or any other contractor

1) The ESTHERAID project made commendable efforts to strengthen the capacities of staff in charge of the PSM chain. However, the project suffered from delays in the procurement of ARVs and laboratory reagents to the Ministry of Health by the Global Fund. Any future project should consider devising an emergency ARV procurement system either on its own or through a partnership with organisations offering this type of service.

2) The ESOPE patient management system should be reassessed, depending on the focus of data collection, whether for clinical case management or programmatic monitoring. As a comprehensive PLHIV database, it contains a wealth of information about HIV case management, including long-term follow-up, which can be used for clinical epidemiology or research purposes, provided the database is up to date. ESOPE is similar to the Follow-up care of Clinical HIV infection and AIDS (FUCHIA) system developed by Epicentre, the epidemiology group of Médecins Sans Frontières, for their HIV clinical programmes. It is not *per se* a tool for programme management. Since ESOPE does not provide data for programme management, a parallel system has to be set up to document programmatic indicators.

3) A project focused mainly on capacity building should include output indicators measuring directly the results of capacity building interventions, without being affected by factors such as ARV and reagents procurement or political unrest that the project cannot control.

4) The exit strategy should be a component of any large project, to prevent realisations from crumbling soon after financial support expires. Most vulnerable are the non-government staff receiving compensation directly from the project. The contractor should make sure that staff remaining necessary for interventions after the end of the project get sponsored by another donor. Whenever possible the exit strategy should include a handover/takeover period.

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Annex 1

Terms of Reference, ESTHERAID end-of-project evaluation

TERMS OF REFERENCE

Expertise France
(Formerly: Ensemble pour une Solidarité Thérapeutique Hospitalière en Réseaux) [ESTHER])
ESTHERAID Project
End of Project Evaluation

PURPOSE OF THESE TERMS OF REFERENCE

These Terms of Reference (TOR) serve as an overall framework for the services to be provided under this project.

DESIRED TIMEFRAME

Requested start date:;	**completion date:**
Duration of contract period: 3 months;	number of working days: **30 days**

TERMS OF REFERENCE

Background

UNITAID funded projects have generated long-term, sustainable price reductions on paediatric and second-line antiretrovirals (ARVs). It was noted, however that in certain countries — Benin, Burkina Faso, Central African Republic (CAR), Cameroon and Mali— the availability and usage of these drugs remained limited at major treatment care centres (TCC), hereby impacting the quality of patient care and antiretroviral treatment (ART) scale up. Common reasons explaining the irregular stock level of these ARVs and their low consumption rate have been identified: 1) the procurement and supply modalities are not adapted to the management of these relatively recent inputs; 2) the demand from the major TCC is too low and/or irregular per ARVs formulations owing to the capacity of laboratories and hospital services in diagnosing HIV-infected children or in identifying treatment failure, in referring, treating and monitoring patients in need of paediatric or 2nd line ARVs; and 3) there is a lack of reliable data to correlate ARVs supply to the real hospital needs and to ensure proper ARV quantifications and forecasts.

To address the issues identified above, UNITAID Executive Board approved in July 2008 (EB8) the ESTHERAID project; the project closed its activities in December 2014. The overall project goal was to

increase the number of patients on pediatric and/or second line ARVs from 8 to 15 HIV TCCs in Benin, Burkina Faso, CAR, Cameroon and Mali.

The primary project objectives were:

- Improve the paediatric and/or second-line ARV supply management system from the central medical store and its depots to about 10 [8-15] selected TCC by applying ARV management tools in decision-taking, supply quality assurance, storage procedures and thereby ensuring a continuous supply of quality ARVs to the selected TCC.
- Optimize and/or extend the required HIV care offer in about 10 [8-15] selected TCC for identifying, rationally treating and monitoring patients needing paediatric and/or second line ARVs in line with national/WHO HIV Standard Treatment Guidelines (STGs); and,
- Improve logistic information systems and patient monitoring systems in about 10 [6-13] selected TCC for correlating ARVs orders to hospital real needs and thereby compiling and optimizing paediatric and/or 2nd line ARVs and other related inputs quantification and forecasting.

The expected project outputs include

- Output 1: Improved Procurement and Supply Management (PSM) systems from Central Medical Store (CMS)/warehouses to the selected TCCs by applying ARV management tools in decision-taking, supply quality assurance and storage procedures
- Output 2: Optimized identification, treatment and monitoring of patients needing paediatric and 2nd line ARVs in the selected TCC
- Output 3: Improved ARV stock inventory information systems and patient monitoring systems in the selected

Objectives of the activity

Provide UNITAID with an assessment of the programmatic implementation of the ESTHERAID project with a particular focus on the project's overall impact on the health system.

Scope of work

UNITAID is seeking an evaluator with experience in the field of HIV/AIDS treatment (paediatric and second-line), and supply chain management. Specific expertise in the following areas would be ideal:

- Familiarity with implementing Standard Treatment Guidelines (WHO and national);
- Forecasting of ARVs at a treatment centre level; and,
- Experience with value for money and impact assessment.

Work to be performed

The UNITAID Grant Evaluation Framework aims to assess the grant relevance, effectiveness, efficiency, impact and lessons learned; *see annex 1*. These criteria are same as the Organisation for Economic Co-operation and Development's (OECD) Development Assistance Committee (DAC)

standard evaluation criteria[24] and the Independent Commission for Aid Impact's (ICAI) updated assessment framework[25] with emphasis on lessons learned and value for money/impact.

Specifically, the evaluation will review the overall goals of the project, its outputs (listed below) and the activities for each output against the following questions:

- Relevance
  - Did the goal (impact) and outcome, as indicated in the logframe, align with UNITAID's mission to contribute to scale-up of innovations for treatment of HIV/AIDS?
  - Did the goal (impact) and outcome align with the global response (and global health actors) to HIV/AIDS treatment?
- Effectiveness
  - Were the outputs in the logframe achieved? Were the activities achieved?
  - What were the main factors influencing (or preventing) the achievement of the outputs?
- Efficiency
  - Were the outputs and activities completed according to the project timeline and budget?
- Impact
  - Did the project result in the intended impact?
  - What could be the value for money of UNITAID's investment in this project?
- Lessons Learned
  - What lessons can UNITAID learn about funding this type of project?
  - What can be learned about working in the project countries? What should UNITAID know before funding other projects in these countries?

Document review

At a minimum the following documents are to be reviewed for this assessment:

1. Grant Agreement and all Annexes including the project plan and logic framework
2. Inception report, Annual and semi-annual reports of the Project
3. Memorandums of Understanding with countries
4. Mid-term evaluation
5. ESTHERAID study on project sustainability and success factors (operational research on the economics of health)

Methodology and Place of work

The grant evaluation methodology will involve document review, key information interviews and on-site meetings with the grantee. The evaluators will work remotely from home and will be required to travel to XXX to meet with key stakeholders.

Deliverables

The provider should submit the following deliverables by the dates determined for each evaluation:

[24] http://www.oecd.org/dac/evaluation/dcdndep/39119068.pdf
[25] http://icai.independent.gov.uk/tag/assessment-framework/

1. An Inception report outlining the process for the evaluation including a proposed methodology/approach to the review, a work plan and timeline and a list of interviewees.
2. A draft evaluation report for review and comments by UNITAID and the grantee.
3. A final evaluation report. This may be made available to the public on the UNITAID website.
4. Written recommendations and advice to the UNITAID Secretariat on how to improve the effectiveness and efficiency of UNITAID project planning based on lessons learnt going forward to the end of project.

Method and frequency of interaction required between UNITAID and the provider:

The provider will coordinate work with UNITAID staff and the ESTHERAID project team as required to complete the deliverables. This should take the form of phone/Skype interactions and e-mail.

Payment Terms and schedule (*tbd*)

Payment #	Schedule	% or Amount
First		
Final		

BUDGET (*to be completed once provider identified and rates discussed*)

FINANCIAL COMPENSATION

Remuneration shall be made on submission of satisfactory deliverables as above and/or on number of days worked and submission of detailed corresponding invoices, including breakdown of travel costs.

Annex 2

Outputs listed by country

GOAL (Impact): To contribute to increasing the number of patients accessing pediatric and 2nd line ARVs in selected TCCs			
OUTCOME: To strengthen the national supply chain and the health system capacity to improve the uptake of pediatric and 2nd line ARVs in the selected TCC			
EXPECTED PROJECT OUTPUTS			
	Output 1: Improve the PSM system from CMS/warehouses to the selected TCC by applying ARV management tools in decision-taking, supply quality assurance and storage procedures.	Output 2: Optimize identification, treatment and monitoring of patients needing pediatric and 2nd line ARVs in the selected TCCs	Output 3: Improved ARV stock inventory information systems and patient monitoring systems in the selected TCC.
COUNTRY	**OUTPUTS BY COUNTRY**		
BENIN	Output 1: Improve the PSM system from CMS/warehouses to the 10 selected TCC by applying ARV management tools in decision-taking, supply quality assurance and storage procedures and thereby ensuring a continuous supply of quality ARV to the 10 selected TCC	Output 2: Optimize the HIV care offer for identifying rationally treating and monitoring patients needing pediatric and 2nd line with national/WHO HIV STGs in the 10 selected TCC	Output 3: Improve the ARV and/or HIV related inputs stock inventory information systems and patient monitoring systems in the 10 selected TCC for correlating inputs needs to cohort data and thereby optimizing pediatric and 2nd line ARV quantification and forecasting per site
BURKINA FASO	Output 1: Improve the PSM system (use/application of ARV management tools in decision-taking, supply quality assurance, quality assurance and storage procedures) for a continuous supply of quality ARVs to the selected TCC	Output 2: Optimize HIV care offer for treating patients in line with HIV STGs/WHO at the treatment referral centre covering the 4 selected regions and organize the decentralization of HIV care services and patient referral process between the referral centre and 5 selected peripheral facilities in the health regions of Hauts Bassins, Cascades, Bouche du Mouhoun and the Southwest	Output 3: Improve information systems for correlating inputs needs to consumption/cohort data in the project area
CAR	Output 1: To ensure effective PSM system from CMS/warehousing to the 11 selected TCC where paediatric care services are reinforced/introduced by applying ARV management tools in decision, supply quality assurance and storage procedures and thereby ensuring a continuous supply of quality paediatric ARV to these TCC	Output 2: Put into place paediatric healthcare services at 11 health structures in region 1 and 7 of CAR and optimize the HIV care offer of the pediatric referral centre of Bangui.	Output 3:To improve the ARV and/related HIV inputs stock inventory information systems and patient monitoring systems in the 11 TCC for correlating inputs needs to cohort data and thereby optimizing paediatric ARVs quantification and forecasting
CAMEROON	Output 1: Improve the PSM system from CMS/warehouses to the 13 selected ATCs	Output 2: Optimize the HIV care offer for identifying, rationally treating and monitoring patients needing pediatric and 2nd line ARV in line with national/WHO HIV STGs in the 13 selected ATCs	Output 3: Improve the ARV and/or HIV related inputs stock inventory information systems and patient monitoring systems in the 13 selected ATC for correlating inputs needs to cohort data and thereby optimizing pediatric and 2nd line ARV quantification and forecasting per site
MALI	Output 1: Improve the PSM system from central level to the TCC by applying ARV management tools in decision-taking, quality control and storage procedures and thereby ensuring a continuous supply of quality ARV	Output 2: Optimize the HIV care offer for identifying, rationally treating and monitoring patients needing pediatric and 2nd line ARV in line with national/WHO HIV STGs	Output 3: Improve the ARV and/or HIV related inputs stock inventory information systems and patient monitoring systems for correlating inputs needs to cohort data and thereby optimizing pediatric and 2nd line ARV quantification and forecasting per site

Annex 3

List of documents reviewed

Documents analysed
ESTHERAID Annual Report 2011
ESTHERAID Annual Report 2012
ESTHERAID Semi Annual Report 2013
ESTHERAID Annual Report 2014
Final Report, Mid-Term Review Estheraid project 2012
ESTHER, feedback mid-term external evaluation
ESTHERAID Exit Strategy plan 2014
Benjamin Coriat, Philippe Abecassis, Mamadou Camara and Nathalie Coutinet. Study on ESTHERAID project's sustainability and success factors. Operational research on the economics of health.
ESTHERAID, Memorandum of Understanding for the No-Cost Extension
ESTHERAID, No-Cost Extension. New Logical Framework
ESTHERAID, No-Cost Extension. Country Operational Plans
ESTHERAID, No-Cost Extension. Detailed Budget 2013-2014
ESTHERAID, Financial report 2014 - FINAL

Annex 4

List of persons interviewed face-to-face or contacted by e-mail

4.1 List of persons interviewed face-to-face

Name	Organization	Position	Place
France			
RAGUIN Gilles	ESTHER/EF[(1)]	Director, ESTHER/EF	Paris
MICHON Christophe	ESTHER/EF	Director, Scientific and Medical Department; former Project technical advisor	Paris
BONFILS Aurélie	ESTHER/EF	Technical Expert, Former ESTHERAID Project Manager	Paris
DIENG Mamadou	ESTHER/EF	Responsible for psychological and social support and community health.	Paris
DIONKÉ Fofana	ESTHER/EF	Responsible for Hospital Cooperation. Former Coordinator for CAR	Paris
LAURENT Arnaud	ESTHER/EF	Former Coordinator for ESTHERAID Project in Benin	Paris
Central African Republic			
NAISSEM Alexis	Coordination Expertise France	Health Coordinator	Bangui
BOSSOKPI Igor	Coordination Expertise France	Pharmacist, Head of The Global Fund Project / Expertise France	Bangui
DERABOZONA Edouard	Coordination Expertise France	Responsible Communication	Bangui
NIEMER Henri	Direction de la Lutte contre les Endémies Spécifiques (DLES)	Director	Bangui
YAMBA Fanta	Direction de la Lutte contre les Endémies Spécifiques (DLES)	Pharmacist, PSM Expert	Bangui
SANA Marie-Charlotte	Direction de la Lutte contre les Endémies Spécifiques (DLES)	Monitoring and Evaluation Officer	Bangui
GREMBO Joseph	UCM – Unité de Cession des Médicaments / FM	Coordinator of the Central Medical Store UCM / FM	Bangui
FEISSONA Senam Rosine	National laboratory	Senior Laboratory Technician	Bangui

[(1)] The ESTHERAID project was implemented by the French agency ESTHER. In January 2015 ESTHER merged with five other French government agencies to become known as Expertise France.

AKONDJA YANDJA Jenny	International Federation of Red Cross and Red Crescent Societies	Pharmacist, PSM Manager TB / HIV	Bangui
GODY Jean	Complexe Pédiatrique de Bangui (CPB)	Hospital Director	Bangui
KANGO Christostome	Complexe Pédiatrique de Bangui (CPB)	Medical Doctor	Bangui
Evariste DJIMBELE Edgar	Complexe Pédiatrique de Bangui (CPB)	Medical Doctor	Bangui
NGANARE Clarisse	Complexe Pédiatrique de Bangui (CPB)	Registered Nurse (IDE)	Bangui
ODIO Magloire	Begoua District Health Centre	Medical Doctor, Head of District Health Centre	Bangui - Begoua
KOFFI Monique	Begoua District Health Centre	Midwife, Head of Maternity	Bangui - Begoua
NAMKIAMGA Mireille Rodrila	Begoua District Health Centre	Dispenser, Health Centre Pharmacy	Bangui - Begoua
KUGBA SENGUETTE Parfait-Edmond	Urban Health Center	Senior Health Technician Head of the Centre	Bangui - Bédé Combattant
GOUGODO Rodolphe	Urban Health Centre	“Technicien en Salubrité de l’Environnement”: responsible for epidemiological surveillance	Bangui - Bédé Combattant
DEMAILLOT Claudine	Urban Health Center	Dispenser, Registered Nurse (IDE)	Bangui - Bédé Combattant
Cameroon			
AKAMBA ABAH Jean-Jacques	Coordination Expertise France	National Coordinator, Program Manager – Public Health Officer – Epidemiologist	Yaoundé
MBEKIRI Christophe	Coordination Expertise France	Chargé de Programme OPPERA	Yaoundé
BASSIROU Bouba	Coordination Expertise France	M&E officer, CAMEROON, CHAD and CAR	Yaoundé
MIMBANG MIDOUNGUE Carole Gloria	Coordination Expertise France	ESTHERAID national project coordinator	Yaoundé
ATEBA ETOUNDI Aristide Otto	Direction de la Pharmacie, du Médicament et des Laboratoires (DPML)	Pharmacist, Director	Yaoundé

KOUAKAP DJINOU Solange	DPML	Pharmacien, Sous-Directeur de la Pharmacie	Yaoundé
BOMBAH Jessica	DPML	Sous-Directeur du Médicament	Yaoundé
NJOM NLEND Anne Esther	Centre Hospitalier d'Essos - Pédiatrie	Médecin, Chef de Service Pédiatrie	Yaoundé
BISSECK Anne Cécile	DROS	Directrice	Yaoundé
KOUANFACK Charles	Hôpital Central de Yaoundé (HCY)	Médecin, Chef Service Hôpital de Jour	Yaoundé
AWONO NTEBE Aimée Marie	Hôpital Central de Yaoundé (HCY)	Pharmacienne	Yaoundé
EDIMO Serge Valery	Comité National de Lutte contre le SIDA	Pharmacien GAS	Yaoundé
TARRAFETA Belen	Management Sciences for Health (MSH)	Pharmacist, Senior Technical Advisor	Yaoundé
MENTOU TADZONG Catherine	Management Sciences for Health (MSH)	Senior Technical Advisor / SIAPS	Yaoundé
FETSE TAMA Gérard	Hôpital Régional	Médecin Santé Publique, Directeur	Bafoussam
MOUNGANG Ignace	Hôpital Régional	Registered nurse. In charge of HIV data collection	Bafoussam
LONLACK Constantine	Hôpital Régional	Community worker	Bafoussam
KEPTCHEU TCHANKWÉ Désiré	Hôpital Régional	Chief Medical Laboratory Officer	Bafoussam
MBEUNGA Régine	Hôpital Régional	Opératrice de saisie	Bafoussam
WOUEMBE Blandine	Hôpital Régional	Pharmacienne	Bafoussam
LOVELINE YAFE Ngum	Hôpital Régional	Gestionnaire dépôt	Bafoussam
EKOULI Marie-Louise	Hôpital Régional	Dispensatrice CTA	Bafoussam

4.2 List of persons contacted by e-mail

KABORE N. Firmin - Clinician	Bobo-Dioulasso Hospital. Burkina Faso
PALM Sié Jean Pierre (Dr.) – Hospital General Director	Dédougou Regional Hospital. Burkina Faso.
SERE ADISA Marguerite – Focal point DGPML	General direction of Pharmacy, medicines and laboratories. Burkina Faso.
BAZONGO Martin – Chief designer	CHUYO Hospital. Burkina Faso.
TRAORE Arouna - Coordinator	ESTHER. Burkina Faso.
DOLO Sominé – Responsible for Quality Assurance	National Public Health Laboratory. Mali
DIARRA Yacouba (Dr.) – Responsible for Pharmacy	Focal Point for ESTHERAID at Council on AIDS Prevention and Control (CSLS). Mali
SACKO Kantara (Dr.) – Responsible for Monitoring and Evaluation	Focal Point for ESOPE. Mali
SOUMOUNTERA Ali - Coordinator	Responsible for Psychosocial support and Community health. Mali
AHOYO Mireille (Dr.) - Pharmacist	National AIDS Control Programme. Responsible for PSM. Benin
AFFOLABI Dissou (Dr.) – Prof. of Molecular biology	Responsible for the reference laboratory at the CNHU, Cotonou. Benin
ATAKPA Félix (Dr.) – Pharmacist	In charge of training and supervision. Benin
Bachabi Moussa - Coordinator	National Program against AIDS (PNLS). Benin

Annex 5

List of Goal and Output Indicators

Annex 5

Indicator Template

Results	Indicator	Measurement Type (e.g. number, percentage, country name etc.)	Indicator Numerator	Indicator Denominator	Baseline (2010 or 2011) For Benin and Burkina, 2010 For CAR, Cameroon and Mali, 2011.	End of Project Target (september 2014)	Reporting Frequency	Comments (on indicator measurement, rational, baselines, targets, milestones or any other relevant to the indicator)
Goal (Impact) : To contribute to increasing the number of patients accessing pediatric and 2nd line ARVs in selected TCCs								
Indicator G1	Number of children receiving ARVs	Number	Number of living children 0-14 years receiving ARVs under follow-up at the end of the reporting period (new and existing children receiving ARVs excluding deceased, transferred, stopped and lost to follow-up at the end of the reporting period)	NA	Benin : 539 CAR : 406 Cameroon : 1101 Mali : 1369	Benin : 50% increase CAR : 50% increase Cameroon : 50% increase Mali : 50% increase	Annual	Do not analyze it cumulatively.
Indicator G2	Number and % of patients receiving 2nd line ARVs	Number and %	Number of living patients receiving 2nd line ARVs under follow-up at the end of the reporting period (new and existing patients receiving ARVs excluding deceased, transferred, stopped and lost to follow-up at the end of reporting period)	Number of living patients under follow-up at the end of the reporting period (new and existing patients excluding deceased, transferred and lost to follow-up at the end of reporting period)	Benin : 365 (5.5%) Burkina Faso : 170 (2.5%) Cameroon : 2043 (5.8%) Mali : 2117 (10.2%)	Benin : 100% increase Burkina Faso : 100% increase Cameroon : 100% increase Mali : 100% increase	Annual	Reference : 3% of switch from 1st to 2nde line. Do not analyze it cumulatively.
Output 1: Improved PSM systems from CMS/warehouses to the selected TCCs by applying ARV management tools in decision-taking, supply quality assurance and storage procedures								
Indicator O1.1	Duration of stock-out for each designated tracer ARV at treatment care center level (with nb of days, explanation and action taken if available)	Number of days	Days	NA	Benin : (1 stock out of LPVr all dosage) Burkina Faso : (4 stock outs of TDF/FTC) CAR : AZT/3TC/NVP 60/30/50mg = NA LPVr 100/25mg = NA LPVr 80/20mg/ml = 51 Cameroon : AZT/3TC/NVP 60/30/50mg = 159 LPVr 100/25mg = 127 LPVr 80/20mg/ml = 80 Mali : AZT/3TC/NVP 60/30/50mg = 368 LPVr 200/50mg = 365 TDF/FTC 300/200mg = 485 TDF/3TC 300/300mg = 450	Benin : 0 Burkina Faso : 0 CAR : 0 Cameroon : 0 Mali : 0	Annual	On baseline, number of stock out were collected. Duration has been collected from 2011
Indicator O1.2	Number of people trained on SOPs related to PSM system (related to activities covered by section 1)	Number		NA	Benin : 0 Burkina Faso : 0 CAR : 0 Cameroon : 0 Mali : 0	Benin : 87 Burkina Faso : 173 CAR : 72 Cameroon : 415 Mali : 292	Semi annual & Annual	

Output 2: Optimized identification, treatment and monitoring of patients needing pediatric and 2nd line ARVs in the selected TCC								
Indicator O2.1	Number of CD4 and PCR HIV (VL monitoring or Early infant diagnosis) performed	Number	Number of tests done by reporting period	NA	Benin : CD4 = 13413 VL = 844 Burkina Faso : CD4 = 2714 VL = 178 CAR : CD4 = ND EID = 453 Cameroon : CD4 = 12551 VL = 199 Mali : CD4 = 11376 VL = 949	Benin : CD4 = 15000*3/4 = 11250 VL = 10000*3/4 = 7500 Burkina Faso : CD4 = 10000*3/4 = 7500 VL = 5000*3/4 = 3750 CAR : CD4 = 3000*3/4 = 2250 EID = 1500*3/4 = 1125 Cameroon : CD4 = 30000*3/4 = 22500 VL = 20000*3/4 = 15000 Mali : CD4 = 12000*3/4 = 9000 VL = 10000*3/4 = 7500	Annual	Final target has been adjusted to the 3 quarters instead of the entire year as the end of project is september 2014.
Indicator O2.2	Number of people trained on optimization of care offer (related to activities covered by section 2)	Number	Number	NA	Benin : 0 Burkina Faso : 0 CAR : 0 Cameroon : 0 Mali : 0	Benin : 788 Burkina Faso : 1175 CAR : 383 Cameroon : 759 Mali : 561	Semi annual & Annual	
Output 3: Improved ARV stock inventory information systems and patient monitoring systems in the selected TCC								
Indicator O3.1	Number of sites with patient monitoring tool	Number	Number of sites	NA	Benin : 0 Burkina Faso : 0 CAR : 0 Cameroon : 0 Mali : 0	Benin : 10 Burkina Faso : 8 CAR : 11 Cameroon : 13 Mali : 15	Annual	
Indicator O3.2	Number of sites with stock management tool	Number	Number of sites	NA	Benin : 0 Burkina Faso : 0 CAR : 0 Cameroon : 0 Mali : 0	Benin : 10 Burkina Faso : 8 CAR : 11 Cameroon : 13 Mali : 15	Annual	
Indicator O3.3	Number of people trained on data information system (related to activities covered by section 3)	Number	Number	NA	Benin : 0 Burkina Faso : 0 CAR : 0 Cameroon : 0 Mali : 0	Benin : 125 Burkina Faso : 140 CAR : 103 Cameroon : 210 Mali : 307	Semi annual & Annual	Number of people trained for the tools in indicator O3.1 and O3.2 will be given in the comments section

Annex 6

Logframes vs. Achievements - Five countries

CAMEROON		
OUTPUTS	**ACTIVITIES**	**RESULTS/PRODUCTS**
Output 1: Improve the PSM system from CMS/warehouses to the 13 selected ATCs	Activity A1.1: Formalize operation of central and regional coordination platforms	Regional and national PSM Coordination platforms introduced (workshops held, operating process drawn). Information channel concerning supply, stocks and consumption ensured (annual report 2012). Operating manuals for the regional coordination platform prepared for each region (semiannual report 2013). Yearly meetings held by the 10 regional and the national platforms (annual report 2014). Reference guide on Standard Procedures for Pharmaceutical Supply Management are available in French and English (annual report 2014).
	Activity A1.2: Support establishment of national HIV input quantification system	Adoption of standardized methodology for ART quantification: indicators, data collection and circulation and adaption of manuals (annual report 2012). Regional quantification tools revised and delivered to regional Bureaus of the national committee against AIDS (annual report 2014). National team trained by an international expert to use the quantification tool at regional level (annual report 2014). 2 integrated supervisions missions of the DPML for the 10 regions were held (annual report 2014).
	Activity A1.3: Support establishment of modernized stock management system at central and regional level	- **MEDISTOCK** software (at that time in development stage in Benin) to be adapted for the management and provision of ARVs in all 5 EA countries. - A Cameroonian version of the MEDISTOCK software from Benin was planned to be adopted and developed (semiannual report 2013). - The lack of progress and fonctionnality of MEDISTOCK had this initiative cancelled and forced each country to find individual solutions. Replaced with an already existing stock management software called **VINDATA** from a Cameroonian developer. - **VINDATA** was rolled out in 3 pilot sites with large cohorts (Hôp Central Yaoundé, Hôp La Quintinie Douala, Hôp de Bamenda) and 29 users were trained (annual report 2014).
	Activity A1.4: Raise awareness/train agents in updated good PSM management practices and competence networking	3 pharmacists received grants to attend university courses (DIU) in Pharmaceutical Management in Ouagadougou (annual report 2012). Implementation of a Network of "Centrales d'Achats Pharmaceutiques Régionales" (CAPR) and treatment centres to handle distribution issues (annual report 2012). 6 pharmacists attended the DIU in "Managing Pharmaceutical supplies in the fight against HIV, TB and malaria in Sub-Saharan countries" in Ouagadougou (semiannual report 2013). Two training workshops in best management practices for ARVs (semiannual report 2013). Biannual coordination meetings of regional medical stores (semiannual report 2013). 5 pharmacists attended the DIU in pharmaceutical management in Ouagadougou. These professionals trained another 20 pharmacists from the public sector (annual report 2014). A consultant trained a group of national trainers in ART management. The national trainers then trained a total of 129 care providers. (annual report 2014). The guide on Good Dispensing /Stock Management Practices for Paediatric ARV Treatment made available (annual report 2014). The projected 3 missions with the ACAME were held: 1 mission to analyze the current situation, 1 training mission (8 people), and 1 monitoring mission (annual report 2014).

Output 2: Optimize the HIV care offer for identifying, rationally treating and monitoring patients needing pediatric and 2nd line ARV in line with national/WHO HIV STGs in the 13 selected ATCs	Activity A2.1: Support implementation of early diagnosis and child diagnostic testing in Treatment Centres (Centres de Traitement Agréés)	Protocol for early diagnosis, based on DBS testing updated. Workshop for the validation of the protocol (semiannual report 2013). Other documents were developed: training manuals, guide to early HIV diagnosis. Printing and dissemination (semiannual report 2013). The 3 reference documents on DBS/EID were developed and delivered (annual report 2014). 2 workshops provided training to around 40 people on early diagnosis for children (annual report 2014).
	Activity A2.2: Capacity building in HIV care for prescribing doctors	1 expert hired to simplify paediatric protocols and update the Standard Treatment Protocols (annual report 2012). Hospital twinning partnership with Trousseau Hospital in France (annual report 2012). Training of prescribing doctors. Around 100 healthcare professionals and paramedics trained (annual report 2012). Several regional workshops held to train prescribing doctors on the provision of care for HIV-infected children (semiannual report 2013). Guide for treatment of children updated plus Memento in line with the latest care giving guidelines. Both validated (annual report 2014). Two training workshops on treatment for children held (50 people trained) (annual report 2014) Training workshop on HIV infected children and psychosocial follow-up (22 people trained) (annual report 2014). Training workshop for regional referral doctors (25 persons) (annual report 2014) Action plans for pediatric care deployment set up for each Treatment Centre (Centre de Traitement Agréé - CTA) by the ESTHERAID pediatric expert (annual report 2014).
	Activity A2.3: Capacity building in treatment education and ARV dispensing	Patient education tools developed through three sub-regional workshops (semi annual report 2013) . Guide of good practices for pediatric ARV dispensing finalized in CAR and planned to be adopted in Cameroon (annual report 2012). Trainers received courses in pediatric patient education (semiannual report 2013). 9 trainers trained during five two-day sessions. They trained later 125 actors in 5 sessions (annual report 2014) Supervision training guide created and 22 actors (no details) trained in it (annual report 2014). Supervisions training sessions undertaken in 13 CTAs (annual report 2014). 2 psychosocial support supervision missions on treatment for children conducted in 3 Treatment Centres (not identified) (annual report 2014).
	Activity A2.4: Capacity building for 13 TCC laboratories	3 laboratory technicians attended the university diploma on Biological retro virology in Dakar (annual report 2012). 4 biologists attended the university diploma in biological retro virology in Dakar (semiannual report 2013). Short term national technical assistant for establishment of maintenance contracts for equipment in the laboratories supported by ESTHERAID (semiannual report 2013) Support for the maintenance of 15 CD4 machines in 13 CTAs. The maintenance contract for VLT at the Centre Pasteur in Garoua is financed by the project (annual report 2014). Laboratory technicians received training in CICM of Bamako (Fondation Mérieux) (annual report 2014) 3 biologists received grants for University diploma of retro virology in Dakar (annual report 2014)

Output 3: Improve the ARV and/or HIV related inputs stock inventory information systems and patient monitoring systems in the 13 selected Treatment Centres for correlating inputs needs to cohort data and thereby optimizing pediatric and 2nd line ARV quantification and forecasting per site	Activity A3.1: Strengthen system for data collection and caseload monitoring at sites	Assessment to establish a pediatric monitoring system needs (annual report 2012). ESOPE software installed in 13 sites and users trained (annual report 2012). Evaluation of the tools listed below for reporting data on pediatric HIV care in Cameroon (semiannual report 2013). - an operating manual on collection, management and transfer of data on pediatric HIV care -medical record to monitor new born exposed to HIV -medical record to monitor HIV-infected children Medical records to follow up exposed and infected children created. Diffusion and training of users (annual report 2014). ESOPED (ESOPE pediatric) set in 5 CTAs. Databases updated, exhaustives and of good quality (annual report 2014).
	Activity A3.2: Install appropriate stock management software and information circuit tools at all levels of drug chain and capacity building in analyzing and processing stock data	The activity will take place once the ARV version of the MEDISTOCK program is fully developed and adapted to Cameroon (semiannual report 2013). However, this never happened. MEDISTOCK was replaced with VINDATA, installed in 3 pilot sites (Hôpital Central, Yaoundé; La Quintinie, Douala; Bamenda Hospital).
	Activity A3.3: Support integration of collection system for WHO drug chain performance indicators in SYNAME (Système National d'Approvisionnement en Médicaments Essentiels)	System for monitoring pharmaceutical channel performance using AMDS indicators identified (semiannual report 2013). Workshop held on the collection processes of indicator (semiannual report 2013). Actors at the central and regional medical stores and the Treatment Centres (CTA in French) trained in the collection and analysis of AMDS indicators (semiannual report 2013). 4 training workshops organized by a national consultant to set up the AMDS indicators. A supervision training workshop was provided to check on the use of the indicators (annual report 2014).
	Activity A3.4: Project monitoring	Activity planning workshops per project objectives conducted in Yaoundé (april 2011) with the different partners and stakeholders (annual report 2011)

BENIN		
OUTPUTS	**ACTIVITIES**	**RESULTS/PRODUCTS**
Output 1: Improve the PSM system from CMS/warehouses to the 10 selected TCC by applying ARV management tools in decision-taking, supply quality assurance and storage procedures and thereby ensuring a continuous supply of quality ARV to the 10 selected TCC	Activity A1.1: Facilitate the development of an ARV supply plan with all respective in-country stakeholders	Implementation of a procurement and drug distribution coordination mechanism (implicating MoH and stakeholders), and a National Committee in charge of forecasting, quantification and procurement monitoring (annual report 2011). Procedures manual for data collection finalized and validated in May 2013 (semiannual report 2013). Quantification tools to estimate HIV commodities revised by ESTHER and validated (semiannual report 2013).
	Activity A1.2: Reinforce the supply chain management of paediatric and 2nd line ARV at CMS and its depots	Quality assurance system of the Central Medical Store (CMS) assessed by International technical assistance (AEDES). Reinforcement strategy validated (annual report 2011). Introduction of a quality assurance system at the CAME and its regional depots and introduction of a QA manual of good storage and distribution practices. 2 members received QA training (Quamed in Kinshasa) (annual report 2012). CAME's quality assurance manual approved since july 2012 (semiannual report 2013). Reconfiguration of CMS's
	Activity A1.3: Reinforce the ARV storage, dispensing tracking and stock management in the 10 selected TCC	Data processing system (patient monitoring and supply) evaluated by technical assistance. SOP guide for data collection produced (annual report 2011). The 10 ARV dispensing points were aligned, refurbished and equipped. 8 out of 10 sites comply with management and dispensing procedures (annual report 2012). Updating of the dispensing centers, with equipment to ensure better ARV storage conditions (semiannual report 2013). Capacity building of the members of the national committee for drug certification, with the help of the Burkinabe's Drug Regulation Authority (25 people trained) (annual report 2014). National drug procurement guide completed by a National expert (annual report 2014).
	Activity A1.4: South capacity building in drug supply management (regional training diploma)	The Global Fund Managers of the CMS and the Supply Manager of the NACP followed DIU in drug management in Ouagadougou (annual report 2011). 14 pharmacists (eight in 2011, three in 2012 and three in 2013) working in PLWHA care centres and CAME have studied a university diploma in "Pharmaceutical Supply Chain Management in the fight against HIV, TB and Malaria in Sub-Saharan countries" in Ouagadougou (semiannual report 2013). 3 University Diplomas sessions paid on Management of pharmaceutical activities. All 11 ESTHERAID on site stock managers trained (annual report 2014). The national ARV procurement officer trained on the quantification of laboratories commodities (annual report 2014).

Output 2: Optimize the HIV care offer for identifying rationally treating and monitoring patients needing pediatric and 2nd line with national/WHO HIV STGs in the 10 selected TCC	Activity A2.1: Reinforce diagnostic capacities and biologic monitoring	1 biologist from the National Reference lab received university diploma in retro virology (Dakar) (annual report 2011) Training and technical assistance in partnership with French Hospitals (Saint Antoine, Besançon and Grenoble hospitals) in viral load, treatment failure and second line switch (135 persons) (annual report 2011). Rehabilitation of CNHU laboratory and training of staff (UD in retro virology) (annual report 2012). Shortages of reagents, consumables and small equipment: ESTHER validated by UNITAID to conduct purchase to cover six month stock gap at the National University Hospital (CNHU) laboratory (1500 tests kits) (semiannual report 2013). The laboratory at the National University Hospital of Cotonou renovated and operational (semiannual report 2013). 3 biologists studied for a university diploma in retro virology in Dakar (semiannual report 2013) (semiannual report 2013). Development and implementation of a national quality assurance system for biology, immunology and virology processes (semiannual report 2013). ESTHERAID finance maintenance of PCR at the LNR (annual report 2014). 2 biologists received grants for a University Diploma in retro virology (annual report 2014). ESTHERAID supported the wages of the doctor during the mission of the Hospital Saint Antoine (annual report 2014). 23 laboratory technicians trained in technology and quality assurance (in Mali and in Benin) (annual report 2014). Operational standard guideline and a quality assurance manual written by a consultant (annual report 2014). The doctor in biology from LNR received training in quality assurance (INTERTEC) (annual report 2014). A local software (GesLab) installed in 17 sites to trace laboratory results and samples. Training of users (annual report 2014).
	Activity A2.2: Promote the early detection of infants HIV infected and the referral of mother and children requiring antiretroviral therapy in the 10 selected TCC	Plan to optimize sample and test results circuit defined by International technical assistance (AEDES) (annual report 2011) Feasibility study to install viral load at the CNHU (University Hospital Center) conducted (annual report 2011) National guidelines on PMTCT norms and procedures revised (by hospital twinning actions and experts) (annual report 2012). Training of midwifes and mechanisms for the proactive detection of potentially infected babies put in place (annual report 2012). Training of midwives on the identification of HIV infected pregnant women and new-borns, referral and treatment HIV positive mothers (semiannual report 2013). Evaluation of PMTCT services at four care centers (Abomey, Lokossa, Natitingou, and Parakou) by a pediatrician, plus training of medical and paramedical staff in PMTCT services in early diagnosis and treatment (51 people trained) (semiannual report 2013). System for proactive research among newborn babies and infants potentially infected with HIV implemented (semiannual report 2013). Evaluation of the existing nutritional care provision (semiannual report 2013). The National guide "Normes et procedures PTME" reviewed (Benin chose option B+)(annual report 2014). MTCT kits made available at peripheral level (annual report 2014). Several missions of the ESTHERAID pediatric expert to improve children treatment, set up nutritional protocols and trainings of the teams (annual report 2014).
	Activity A2.3: Improve prescribing and dispensing practices regarding paediatric 2nd line ARV in the 10 selected TCC	Sub regional seminar on HIV pediatrics organized in Cotonou (September 2011). 13 doctors from the 10 selected TCC in Benin were trained (annual report 2011). 3 doctors were granted scholarships for HIV care training for the Ouida HIV course (annual report 2011). Medical and paramedical staff of all sites trained in pediatric care and managing therapeutic failures (annual report 2012). Doctors attended pediatric seminars in 2011 and 2012 (semiannual report 2013). Training in good prescription practices, interpretation of results and second line therapy for doctors (seminars, DIU in "Training in the Provision of Care for PLWHA in Sub-Saharan Africa" Ouida 2011, twinning programs) (semiannual report 2013). Updating of national guidelines for patient carte standards and policy. Printing and diffusion (semiannual report 2013). Evaluation of the viral load management procedure at the Cotonou university teaching hospital (CNHU) by a specialist from the north.) (semiannual report 2013). 2 training sessions for medical and paramedical staff on therapy failure and HIV Hepatitis C co infection (30 people trained) (semiannual report 2013). Guide for ARV treatments dispensing validated, and patient education toolkits compiled (semiannual report 2013). Pediatric interdisciplinary seminars (Dakar) followed by a national cascading training (50 people trained) (annual report 2014). Training sessions on therapeutic education by the Hospital in Besancon (annual report 2014). Hospital in Grenoble and in Charleville Mezieres came on mission to support teams (annual report 2014). Guide on good dispensation practices in place and available. Training of users (annual report 2014).

Output 3: Improve the ARV and/or HIV related inputs stock inventory information systems and patient monitoring systems in the 10 selected TCC for correlating inputs needs to cohort data and thereby optimizing pediatric and 2nd line ARV quantification and forecasting per site	Activity A3.1: Reinforce stock management capacities in the pharmacy of the 10 selected TCC	Development of the software HIV MEDISTOCK (annual report 2012). Tools for managing ARV treatments revised and validated at national level. Standardization of the management of ARV treatments at dispensing centers (semiannual report 2013). Training seminar on the new tool organized (semiannual report 2013). Paper and software version of the tools developed and provided for adapting the MEDISTOCK software (semiannual report 2013). Short version of the guide to data collection procedures and tools finalized (semiannual report 2013). Preparation for the roll out of MEDISTOCK software (semiannual report 2013). According to the "Country Operational Plan of Benin", some activities were planned in 2014. However, no activities were carried out here (annual report 2014).
	Activity A3.2 : Reinforce patient monitoring capacities in the 10 selected TCC	ESOPE made available in all 10 sites. A pool of 5 national trainers ensures monitoring and evaluation. Field visit conducted to supervise data collection and ESOPE implementation (annual report 2011) Training seminar on data collection (30 people) (annual report 2012). Standardized system of supervision integrated into the national system (annual report 2012). Training workshop organized be a ESTHER expert for pediatrics providers and PNLS staff (use of pediatric ESOPE) (semiannual report 2013). Paper version of the medical consultation record for PLWHA prepared by a national expert. The record allows patient follow up and is aligned with ESOPE data (semiannual report 2013). Workshops for the updating of ESOPE databases organized (semiannual report 2013). Purchase of IT equipment and training of staff in data entry (semiannual report 2013). Training workshop on ESOPE database indicators (semiannual report 2013). 6 month assistance for quality control and database updated (annual report 2014). ESOPE software updated. Maintenance contract with the developer set (annual report 2014). Validation workshops on data collection (annual report 2014). Staff trained on ESOPE (annual report 2014).
	Activity A3.3 : Support implementation of selected WHO PSM performance indicators	Workshop to validate and adopt a system for monitoring performance along the supply chain and distribution (semiannual report 2013). Procedures and management tools to collect AMDS indicators adapted and health care staff trained on it (semiannual report 2013).
	Activity A3.4 Project monitoring	Programmatic seminar and planning workshops organized in Cotonou with the different stakeholders (semi annual report 2011)

CENTRAL AFRICAN REPUBLIC		
OUTPUT	**ACTIVITIES**	**RESULTS/PRODUCTS**
Output 1: To ensure effective PSM system from CMS/warehou-sing to the 11 selected TCC where paediatric care services are reinforced/intro duced by applying ARV management tools in decision, supply quality assurance and storage procedures and thereby ensuring a continuous supply of quality paediatric ARV to these TCC	Activity A1.1: Elaborate a national referral document of pharmaceutical norms	The HIV treatment manager of the CMS attended the DIU "Gestion des Activités pharmaceutiques" in Ouagadougou. (Annual report 2011) The Head of the CMS received training in pharmaceutical quality assurance at the "Centrale Humanitaire Médico-Pharmaceutique" (CHMP) in France (Annual report 2012). The director of pharmacy and drug management at the 'Direction des Services Pharmaceutiques, des Laboratoires et de la Médecine Traditionnelle' (DSPLMT) also received training in quality control at the CHMP in France. (Semiannual report 2013) A team consisting of an international expert, the national ESTHERAID pharmaceutical manager and the DPM completed the National Referral Document of Pharmaceutical Norms and Standards (Annual report 2014).
	Activity A1.2: Improve capacities for the distribution and storage of ARVs at CMS, warehouses and TCC	Four national pharmacists received training in decentralization of paediatric care (Annual report 2012). Evaluation of the CMS storage and stribution processes by 2 International experts (Annual report 2012) Working group to revise trainer guidelines for stock management and distribution for HIV commodities (Semiannual report 2013) Training of national trainers in stock management and distribution practices for HIV commodities, followed by cascade training of 22 people. (Semiannual report 2013). 5 Pharmacists attended the international DIU in “Case management of PLHA in Sub Saharan Africa” (Semiannual report 2013). 3 pharmacists received practical training in supply/stock management and dispensing for HIV paediatric inputs (Semiannual report 2013). The National Stock Management and Distribution Manual was completed by a technical expert, and stock managers trained in it (Annual report 2014). 5 stock managers received training in stock management in Bamako (Annual report 2014). 2 persons received a training in Laboratory commodity quantification in France (Annual report 2014)
	Activity A1.3: Develop and introduce drugs quality control system	Officials of the CNLS and the "Unité de Cession des Médicaments" (UCM) attended in June 2012 a seminar at WHO on national drug policy and quality control. However, support for the implementation of quality control at the MoH/DPM level was postponed to 2014 (Annual report 2012). “At present, drug quality control is not operational at national level”. No details provided. (Annual report 2014 page 33-34)
	Activity A1.4: Integrate PSM performance indicators in the LMIS	An expert pharmacist of ESTHER based in West Africa was identified in 2013 to conduct these activities in a comprehensive manner for the five ESTHERAID project countries (annual report 2012). However, the activity was removed due to the context, and replaced by support to implement a database and a computer system at DPM level to improve data collection/consolidation. (SIAMED, a model System for Computer-assisted Drug Registration, developed by WHO). 21 ART stock managers trained in data consolidation and indicators, but all paper based or EXCEL based (annual report 2014).
	Activity A1.5: Promote South South capacity building of central medical stores in the 5 ESTHERAID countries	ACAME capacity building activities were cancelled as it was impossible to send technical experts to Bangui in 2013-2014, because of local security issues (annual report 2014). There were no visits of international consultants for Technical Assistance between March 2013 and end of 2015. TA was provided by a national TA consultant, CAR pharmacist, based at DPM.

Output 2: Put into place paediatric healthcare services at 11 health structures in region 1 and 7 of CAR and optimize the HIV care offer of the pediatric referral centre of Bangui.	Activity A2.1: Carry out an inventory for defining the decentralization of paediatric services strategy	The strategy for the decentralization of HIV pediatric care was drawn by a team of international experts and a national expert, in collaboration with national health authorities and the twinning partnership was validated (annual report 2012) The CPB (Centre Pédiatrique de Bangui), i.e. the main consulting unit for paediatric care was refurbished and functional (annual report 2012). Paediatric medical care was set up in 4 sites, Bédé-Combattant, Bégoua, Mbaiki and Boali (semiannual report 2013) The paediatric consultation unit was renovated and has been operational since February 2013 (semiannual report 2013).
	Activity A2.2: Integrate the early diagnosis of children into the healthcare services provided	National key health personnel involved in HIV care received international training: 1 Doctor attended the DIU in retrovirology, 1 doctor the DIU in HIV Care, both in Dakar and 4 representatives of the CPB attended a paediatric seminar in Cotonou. (Annual report 2011) All sites (including Mbaiki) routinely practice early diagnosis (annual report 2012). A national system for the early screening of pediatric HIV using DBS was finalized and validated (semiannual report 2013). Training for laboratory technicians in neonatal screening and in the DBS technique in 10 sites (semiannual report 2013). The procedure for sending DBS specimens to the laboratory and to collect results was defined (semiannual report 2013). Financial support was secured to bring DBS/EID specimens and collect results (Annual report 2014)
	Activity A2.3: Organize laboratory services to ensure pediatric screenings and biological monitoring of children	1 technician of the "Laboratoire National de Biologie Clinique et de Santé Publique" (LNBCSP) did an internship in France at the Hôpital Européen Georges Pompidou (HEGP) in PCR technique (annual report 2011). 3 technicians of the Laboratoire National de référence (LNR) were trained in viral load test testing in Paris (HEGP) (annual report 2012). 2 biologists received international training in HIV virology (Diploma at university of Dakar) (annual report 2012) Mentoring provided by the Amiens teaching hospital on Good Laboratory Practices (**GLPs)** and laboratory Standard Operating Procedures (SOPs). (Annual report 2012) Mentoring from HEGP to update QC procedures at the LNR and purchase of control reagents (annual report 2012). The LNR was completely renovated to enable carry out molecular biology (annual report 2012). A technical assistant identified training needs for each laboratory department, and a training plan was devised (semiannual report 2013). Training of local staff in GLPs and laboratory SOPs was organized at each site (semiannual report 2013). The manager of the LNR and the head of the 'Hôpital Communautaire' lab received training at the Centre for TB and AIDS Research in Mali (SEREFO), Bamako in Viral Load testing and quality control (semiannual report 2013). Financial support for the acquisition and maintenance of the equipment of the LNR (following ransacking in 2013) (annual report 2014). Implementation of the laboratory PCR analysis quality assurance system and launching of VLT at the LNR with the support of the Hôpital Georges Pompidou in Paris (apparently the equipment was installed and financed by AFD in 2011, but had never been operational) (annual report 2014). The director of the LNR received training at the Hôpital Geoges Pompidou. 2 biologists received a scholarship for the DIU in retrovirology in Dakar (annual report 2014). The laboratory network was organized and training sessions in good laboratory practices were conducted for 25 technicians in Bangui (annual report 2014). Finally, quarterly meetings of the monitoring committee were organized (annual report 2014).

Output 2: continued	Activity A2.4: Introduce paediatric healthcare services, the early treatment of children and ongoing monitoring in the selected TCC in collaboration with the "Centre Pédiatrique" of Bangui.	Evaluation of the support group to define needs in training, tools and redefine the mother/child care circuit (annual report 2011). 9 medical doctors from the CPB and 4 medical doctors from peripheral sites were trained in paediatric treatment protocols through ESTHER's annual paediatric seminar, mentoring by Necker Hospital and HIV/AIDS training grants in Dakar (DIU in HIV pediatric case management) (annual report 2012). The new PMTCT recommendations from WHO were approved at national level, and the country switched from option A to option B+, i.e. treatment for pregnant HIV positive women (annual report 2012). The agent responsible for the evaluation/monitoring at the Direction Générale de Lutte contre le SIDA (DGLS) attended a seminar at the Centre Africain d'Etudes en Gestion (**CESAG)** in Dakar. Paediatric treatment guidelines finalized by expert group and ESTHER pediatric expert (semiannual report 2013). 4 practical courses planned in 4 French hospitals: Necker, Brive, Amiens and HEGP (HEGP and Brive cancelled) (Country Operational plans and semiannual report 2013) Tutoring in pediatric care an 10 sites, 25 staff members trained in pediatric treatment and management of therapeutic failure (annual report 2014). 4 physicians received grants for DU on HIV in Ouagadougou (annual report 2014). 2 physicians attended paediatric workshops in Mali (annual report 2014). 25 staff attended a training session in interpreting VL results (annual report 2014). As a result: 9 sites are operational with pediatric care (there was only one at the beginning of the project) (annual report 2014).
	Activity A2.5: Develop and disseminate good practices for dispensing paediatric ARV treatments in the selected TCC in collaboration with the "Centre Pédiatrique" of Bangui.	A guide for Good Dispensing Practices of ARV at Treatment Centres was developed and validated (semiannual report 2013) Training in good ARV dispensing practices (semiannual report 2013) Services for dispensing paediatric ARV treatments implemented in all sites. Quarterly supervisions training sessions conducted (annual report 2014).
	Activity A2.6: Improve the quality of patient monitoring and parents and children support	Guidelines for treatment education of patients (TEP) and psychosocial support (PSS) adopted (annual report 2012). 10 national trainers trained 48 professionals (annual report 2012). 12 national trainers recruited and trained 55 educators and 22 midwives (annual report 2012). From 2012 onwards, ESTHERAID allowed community health workers to be paid (annual report 2012). Patient education kits developed (semiannual report 2013). 2 ESTHER experts provided training for national trainers in counselling/screening/PPTCT, paediatrics, follow up, diagnosis and adherence. Cascade trainings (semiannual report 2013). 5 psychosocial counsellors and peer educators received training from a group of associations in Niger (semiannual report 2013). Supervision procedures organized in 9 sites in Bangui and Begoua (semiannual report 2013). A reference document on the role of support groups, peer educators and psychosocial counsellors and tools for data collection developed (semiannual report 2013). ESTHER provided support to 4 patients associations and 10 PPTCT support groups (semiannual report 2013). Workshop on TEP tools, 46 health staff trained (annual report 2014). 5 peer educators went on a 2-week training in several hospitals in Niger (annual report 2014). A monitoring platform on care quality was set, and a handbook, "the Care Quality Reference Handbook" created (annual report 2014). 2 meetings per month during 5 months, with 25 attendants. Supervision training session for psychosocial advisers (annual report 2014).

Output 3:To improve the ARV and/related HIV inputs stock inventory information systems and patient monitoring systems in the 11 TCC for correlating inputs needs to cohort data and thereby optimizing paediatric ARVs quantification and forecasting	Activity A3.1 Improve the information system for managing the stock of laboratory reagents and tests at the level of the laboratories in the areas covered by the project	2 experts developed and updated the HIV Laboratory Essential Commodity Quantification Tools/methodology/procedures (annual report 2014). 1 biologist from the LNR and 1 from the IPB (Bangui Pasteur Institute) developed a laboratory good practices reference book (annual report 2014). 2 supervision training sessions of the laboratory staff at ESTHERAID sites (annual report 2014).
	Activity A3.2: Improve the information system for managing medicine stocks at the level of 11 hospital pharmacies, the CMS and warehouses within the area covered by the project	Computerization of Treatment Centres considered premature in 2012-13 (due mainly to the political/security situation). This activity focussed instead on the good management of stock management paper tools (semiannual report 2013 and annual report 2012).
	Activity A3.3: Improve the patient monitoring files and tracking system in the 11 TCC of the project	The national manual for the collection and transmission of paediatric data was validated. National trainers was trained , before training local staff. (Annual report 2012). The harmonized paediatric medical record was validated and distributed (annual report 2012). Staff trained in filling out medical records. ESOPE software installed at the CPB in Bangui, and users trained (semiannual report 2013). Data collection support by the data manager (annual report 2014). Supervision guidelines were completed and 21 professionals were trained (annual report 2014). 4 people were trained in the ESOPE PED (pédiatrique) application in Cameroun. ESOPE PED now operational in 9 sites (annual report 2014).
	Activity A3.4: Monitoring and evaluation of partners' activities and review of project indicators	The project steering committee met for the 3rd time in February 2013 to review activities (semiannual report 2013) Quarterly meetings of the technical project stakeholders and half yearly meetings of partners were held. A document to capitalize and evaluate results of the ESTHERAID project in CAR was written by a consultant (annual report 2014).

MALI		
OUTPUTS	**ACTIVITIES**	**RESULTS/ACHIEVEMENTS**
Output 1: Improve the PSM system from central level to the TCC by applying ARV management tools in decision- taking, quality control and storage procedures and thereby ensuring a continuous supply of quality ARV	Activity A1.1: Develop a drugs quality assurance system	2 agents of the LNS (Laboratoire National de la Santé) and one from the DPM (Direction de la Pharmacie et du Médicament) attended a course on quality assurance at the Centrale Humanitaire Médico-Pharmaceutique (CHMP) in Clermont-Ferrand (semiannual report 2013). Maintenance plan and guide for biomedical equipment developed by a consultant, and a dissemination workshop organized in the CSLS (Cellule Sectorielle de Lutte contre le Sida) (semiannual report 2013). Maintenance contract signed with two local providers for biomedical equipment in six laboratories supported by the project (semiannual report 2013). Metrological alignment of the LNS equipment to ensure that laboratory test results are reliable, done by ESTHERAID (semiannual report 2013). Two 6-day training sessions for national partners lead by an ARV quality assurance and control expert. 11 staffs from the Laboratoire Nationale de la Santé (LNS), 18 supervisors from the DPM (annual report 2014). 2 agents of the LNS trained in Ivory Coast on Quality assurance in the LBCA (Laboratoire de Contrôle de Qualité Bio-Connex Analytique) (annual report 2014). Maintenance of 3 HPLC devices provided (annual report 2014).
	Activity A1.2: Train health professionals in ARV dispensing practices and supplies/stocks management procedures (esp. Paediatric and 2nd line ART)	Design of guides to manage and dispense ARVs in centers providing care for people living with HIV/AIDS (semiannual report 2013). Trainer's guide, training manual and training modules for the management and dispensing of ARVs in TCC (Treatment Care centers) developed. 16 trainers prepared to deliver cascade trainings (semiannual report 2013). 35 staff from the three regions (Mopti, Koulikouro and Bamako) trained in ARV management and dispensation (annual report 2014). 6 pharmacists went on training session on stock management/dispensing in Ouagadougou (annual report 2014). Trainee's handbook and notebook relative to ART managing/dispensing made available in all the regions (annual report 2014).
	Activity A1.3: Improve the formative supervision at treatment centres to optimise activity monitoring	Technical workshop for the revision of the supervisory training guide (semiannual report 2013). The multidisciplinary national supervision guide (trainer's manual and trainee's tools) reviewed (annual report 2014). Training agents trained on the use of it, for integrated supervision, monitoring and supervision techniques. Cascade tuition of 39 staffs in Mopti, Segou and Sikasso (annual report 2014).
	Activity A1.4: Improving the collection of information on PSM plan indicators for all inputs by HCNLS (Haut Conseil National de Lutte Contre le SIDA)	Inventory of the AMDS (AIDS Medicines and Diagnostic Service) indicators collected since 2009, performed by an ESTHER expert and a national technical assistant (semiannual report 2013). Additional indicators to monitor the performance of ARVs supply chain identified. New tools to collect AMDS indicators finalized and present at all levels of the supply chain in Mali (annual report 2014). 3 meetings for data analysis organized, and to be continued by the DPM (annual report 2014). 2 staffs of the DPM went on training session to the DPML (Direction de la Pharmacie, du Médicament et des Laboratoires) in Burkina Faso on quality assurance and data collection (annual report 2014).
	Activity A1.5: Cross -country activities for building capacities of treatment centre and central medical personnel	9 pharmacists studied a DIU in "managing drug supplies in the fight against HIV, tuberculosis and malaria in Sub-Saharan Africa", in Ouagadougou (semiannual report 2013) 8 pharmacists trained on DIU on Medicines procurement management in Ouagadougou (annual report 2014).

Output 2: Optimize the HIV care offer for identifying, rationally treating and monitoring patients needing pediatric and 2nd line ARV in line with national/WHO HIV STGs	Activity A2.1: Build early diagnosis capacities for children born to seropositive mothers and mother and children referral in the project zone	Technical assistance to support virology diagnosis activity. Purchase of equipment. Training workshops attended by agents working in Kayes, Sikasso, Ségou and CHUGT (Centre Hospitalier Universitaire Gabriel Touré) (11 in total). 11 biologists were trained as well in situ (annual report 2012). Support to define supervision strategy by the twinning programme South/south (annual report 2012) ESTHERAID support for the Dry Blood Spot (DBS) circuit (funding of the costs for sampling and returning results) (semiannual report 2013). The laboratory of Kayes teaching hospital received support to develop viral load activity using PCR technique (semiannual report 2013). A guide on Good Laboratory Practices (GLP) developed, and the staff in charge of laboratories in each ESTHERAID region trained on it (annual report 2014). 6 laboratory technicians from Mopti, Sikasso and Segou attended Resaolab training (Foundation Merieux) (annual report 2014). 2 teams from Kayes went on training to the Hospital of Saint Denis and 6 laboratory technicians from Sikasso, Segou and Mopti were trained at the CHU Gabriel Touré in Bamako. Sikasso technicians received a post training monitoring (annual report 2014).
	Activity A2.2: Strengthening the practices of doctors and paramedical staff of stakeholders working in treatment centres	100 people trained in early detection of therapeutic failure, through staff meetings in the regions of Kayes and Sikasso (annual report 2012). Training needs and supervision skills assessed by a multidisciplinary team in the selected centers (all except Mopti due to security issues) (semiannual report 2013) Various training courses organized as a consequence of this assessment: -training in nutritional care, diagnosis announcement for children and managing adolescents -a restitution workshop on pediatrics for 50 Malian practitioners. -a pediatric seminar -appointment of clinical biologists in the regions of Kayes and Sikasso. -training on the interpretation of resistance tests -training workshop on diagnosis and management of treatment failure, for biologists, clinicians and pharmacists and with the attendance of staff from hospital partners (Saint Denis and Angers) (semiannual report 2013) Development of a training framework for pediatric HIV care and support (semiannual report 2013). Capacity building work in PCS (Pediatric Care services) in the field of nutrition and care for adolescents. Centre assessments conducted in Bamako by a public interest group expert (semiannual report 2013). 5 doctors from the regions went on training on pediatric HIV at the CHUGT, and national staff trained on resistance to ARTs (annual report 2014). Clinical biological therapeutic committee were decentralized in Kayes, Koulikoro, Sikasso, Segou and Mopti (annual report 2014). Workshop on therapeutic success held by ESTHER (annual report 2014).
	Activity A2.3: Strengthening the national training strategy for professionals involved in PMTCT referral and treatment activities	5 doctors participated in HIV pediatric seminar in Douala (annual report 2012). Treatment education tools developed in collaboration with the five countries involved in the project. (annual report 2012). 10 practitioners received since the beginning of the project, scholarships to study DIU in "training in comprehensive care for people living with HIV in sub-Saharan Africa" (semiannual report 2013) Counselling and social support activities performed (discussion groups, home visits, psychological monitoring….) (semiannual report 2013) 2 biologists received grant to attend DIU in retro virology in Dakar (annual report 2014) 4 doctors received grants for a DIU in HIV comprehensive care in Ouagadougou (annual report 2014). Thanks to the new tools and the development of training courses, 69 people were trained in Patient treatment Education (annual report 2014) 73 people were trained on psychosocial and social support and monitor HIV+ teenagers (annual report 2014). The National trainer's guide on comprehensive care was completed (annual report 2014).

Output 3: Improve the ARV and/or HIV related inputs stock inventory information systems and patient monitoring systems for correlating inputs needs to cohort data and thereby optimizing pediatric and 2nd line ARV quantification and forecasting per site	Activity A3.1: Improving the collection of information on HIV treatment + PMTCT in centres to improve the quality of consumption estimates	Updating of the national system for collecting overall care data and BEA, PMTCT and pharmaceutical indicators, by a national working group. Trainers, regional doctors and officials trained on the use of the new system (semiannual report 2013). One staff from the CSLS was trained on the monitoring/evaluation of healthcare projects in Paris (semiannual report 2013). 39 data collection managers in Sikasso, Koulikoro and Segou trained on good practices (annual report 2014)
	Activity A3.2: Implementation of a monitoring and evaluation mechanism for treatment and access to antiretroviral therapies	National trainers, data managers and referring physicians trained in ESOPE. Regional supervisors trained in database quality control (annual report 2012). ESOPE software installed in the 15 ESTHERAID centers. Staff was trained on its use and manuals made available. Regional supervision missions held to improve data quality (semiannual report 2013). ESOPE training for regional supervisors conducted by the ESTHER monitoring and evaluation Officer. Inventory of the use of ESOPE software for pediatric patients at the Gabriel Touré national referral hospital performed (semiannual report 2013). The Regional Monitoring and Evaluation managers were trained in the CESAG (Centre Africain d'Études Supérieurs en Gestion) in Dakar (annual report 2014). National ESOPE software installed at the Ministry of public Health, and a maintenance contract signed with ANTIM (Agence Nationale de Telegerance) (annual report 2014) 2 workshops held in 2014 on data updating (annual report 2014) An archiving system was set up in each ESTHERAID site to ensure better conditions (annual report 2014). Several training sessions held (SPSS Statistical Package for the Social Sciences and national ESOPE Software, quality control of databases, data entry) (annual report 2014) Medical follow up records computerized and accessible for 69% of the national cohort. The Database is exhaustive and up to date in 14 sites. National ESOPE is used to elaborate quarterly reports to the UNDP (annual report 2014).
	Activity A3.3: Setting up a project steering committee for monitoring the project indicators	Formation of the project's steering committee, including DPM and PPM (annual report 2011) The steering committee met in May 2013 to monitor ESTHERAID project in Mali (semiannual report 2013). 3 steering committee meetings held in 2014 and supervision missions to ESOPE installations made on ESTHERAID sites (annual report 2014). Training sessions held at central level on using ESOPE (annual report 2014) The Head of PG Hospital and the HIV national program coordinator attend coordination meetings in France (annual report 2014).

BURKINA FASO			
OUTPUT	**ACTIVITIE**	**Subactivities**	**Results/Products**
Output 1: Improve the PSM system (use/application of ARV management tools in decision- taking, supply quality assurance, quality assurance and storage procedures) for a continuous supply of quality ARVs to the selected TCC.	Activity 1.1 A better coordination of institutions and activities at the central level for the definition of	1.1.1 Implement the national HIV pharmaceuticals and diagnostics management Committee (DGPML, CAMEG,	The National Procurement and Stock Management Committee (set up in 2011) had been meeting on quarterly basis since 2012, to quantify HIV commodities [annual report 2012]
		1.1.2 Diffuse the national procurement manual (including management SOPs for all the respective types of HIV pharmaceuticals and diagnostics in use).	The Stock Management Guidelines were developed (annual report 2012) Training workshop on the use of the Guidelines held (semiannual report 2013) The Guidelines were available (print/diffusion) at site level (annual report 2014)
	Activity 1.2 An improveme nt in the rational managemen	1.2.1 Strengthen staff capacities in lab reagents management.	National framework for managing lab reagents in laboratories/pharmacies adopted (annual report 2011) Two national consultants (with the DGPML) elaborated laboratory commodities management modules and a training module for ARV, OI medicines and reagents management (annual report 2011) All the project laboratory staff trained in good management of HIV laboratory commodities (annual report 2012 and semiannual 2013) Printing/diffusion of training materials (semiannual report 2013) Participation in a regional workshop headed by WHO on the building of LMIS (annual report 2014)
	Activity 1.3 An improvement of the quality control/quali ty assurance of HIV tests and biologic	1.3.1 Support the laboratories division of the DGPML and the national laboratory for implementing systematic and regular in- country quality control of HIV tests	Prospective work to improve Quality Control of HIV lab supplies canceled (Country operational plan Burkina Faso) The National Reference Laboratory undertook quality controls of the tests (rapid test, CD4, VL) in the 13 public health regions (annual report 2014)
		1.3.2 Support the laboratories division of the DGPML and the national laboratory for collaborating with external foreign laboratory (for CD4 count and viral load)	No results have been found here.
	Activity 1.4 Better storage and managemen t conditions of inputs at intermediar y levels	1.4.1 Analyze HIV inputs storage condition of the "Directions Régionales de la Santé", depots and TCC in the project zone	Capacity building plan for HIV drug management and storage for TCCs finalized (Annual report 2011) Storage conditions of ESTHERAID supported TCCs assessed in collaboration of the DGPML and equipment and needs identified (Annual report 2011) Infrastructures, storage conditions and stock management procedures in the project area evaluated (Annual report 2012)
		1.4.2 Strengthen the storage capacity of pharmacies to reinforce drugs management quality (DRS, DRD TCC)	Purchase of the equipment to strengthen quality of stores and site pharmacies managing HIV commodities (around 40.000 euros) purchased (annual report 2012) Pharmacies in CHRs Gaoua, Dedougou and Do refurbished (annual report 2014)
	Activity 1.5 GDP SOPs are being applied at an intermediary level, at TCC	1.5.1 Support the DGPLM which will train management teams in Good Distribution Practices (GDP) in the regions and districts	National training course with DGPML on Good Distribution Practices (GDP) held in September 2012, 23 pharmacists trained (annual report 2012) Another training session in second half 2013 (semiannual report 2013), no number provided. Two times per year, supervision sessions organized by regional health management teams to ensure application of GDP (semiannual report 2013)
		1.5.2 Strengthen pharmaceutical actors capacities through diploma	Semiannual report 2013: 12 pharmacists have been granted with scholarships to study DIU in "Pharmaceutical Supply Chain management" at Ouagadougou University (one in 2011, 7 in 2012 and 4 in 2013). Four additional pharmacists received grant for the 2014 DIU (Annual report 2014). In total 16 pharmacist attended the DIU
	Activity 1.6: An improvement in the monitoring of adherence by PLHA and treatment side effects	1.6.1 Develop therapeutic education in TCC	National seminar on drug safety surveillance, to adopt tools and methodology to track and notify ARV medicines adverse effects organized (annual report 2011)
		1.6.2 Strengthen the capacities of staff in dispensing ARV and adverse effects of ARVs, and compliance	Training sessions developed in collaboration with the DGPML in 2012. 79 people trained: 9 on side effects of ARVs, 57 on therapeutic patient education and 13 on Pharmacovigilance (annual report 2012). Patient education training material printed and diffused. (Annual report 2014)
		1.6.3 Reinforce the pharmacovigilance system for recording and monitoring ARV side effects	Training workshops held in 2013, 13 people trained on Pharmacovigilance (semi annual report 2013). 16 staff attended pharmacovigilance workshop (Annual report 2014). Total number of people trained in PV not clear.
	Activity 1.7: South to South capacity	1.7.1 South to South capacity building and sharing experience between 5 ESTHERAID benefiting countries	Missions to monitor the build-up of pharmaceutical qualifications in central medical store (CAMEG). The regional workshop planned in Cotonou was not held (semi annual report 2013 page 52)

Output 2: Optimize HIV care offer for treating patients in line with HIV STGs/WHO at the treatment referral centre covering the 4 selected regions and organize the decentralization of HIV care services and patient referral process between the referral centre and 5 selected peripheral facilities in the health regions of Hauts Bassins, Cascades, Bouche du Mouhoun and the Southwest	2.1: The Outpatient Department (OPD) of CHUSS is effective in the decentralization of TCC in the project zone	2.1.1 Set up a coordination mechanism of care and health system actors to operationalize decentralization	Therapeutic committees functional. Decentralization system is sustainable and supported by national expertise from the CHUSS referral Hospital in Bobo (annual report 2012) Communication system in place between the CHUSS and peripheral sites assessed. Recommendations, action plan and corrective measures implemented(semiannual report 2013) Referral/counter referral system for PLWHA established. Complicated cases referred to CHUSS in Bobo after exchanges between doctors (semiannual report 2013)
		2.1.2 Optimize the HIV testing within the health system/health professional environment	Training in collection, processing and transport of samples took place in 2012 and 2013 (semiannual report 2013) Laboratory software to manage VL samples and results developed and rolled out to trained users. (Annual report 2014)
		2.1.3 Reinforcement of the competences of the agents involved in the care, treatment and monitoring of PLWHA	Training workshop (for 10 medical staff) in therapeutic failure monitoring and Viral Load in July 2011 (annual report 2011) Training sessions in care management of PLWHA were provided by international and national experts in infectious diseases, enabling capacity building of doctors, pharmacists and paramedics (semiannual report 2013). Screening tools developed and rolled out (annual report 2014) Three prescribing doctors received grants for DIU on HIV in Ouagadougou Guide for ART dispensing best practices developed and validated at national level (annual report 2014) Nine doctors trained in DIU training in care management of PLWHA in Sub-Saharan Africa (semiannual report 2013). One Nurse received international training in transmission of HIV and other STDs at the end of 2012. One doctor received training in data analysis using STATA at the Pasteur Institute, December 2012 (semiannual report 2013)
		2.1.4 Tutor peripheral TCC by the CHU SS	Training workshop of CHUSS teams in charge of tutoring peripheral TCCs (annual report 2011) Coordination mechanism of care and communication plan validated. Staff of CHU Sanou Souro capacitated to train and monitor TCCs (annual report 2011). TCCs received formative supervision from the CHUSS Bobo (semiannual report 2013).
		2.1.5 Set up of a steering committee for monitoring project indicators	Workshop in September 2014 to capitalize and evaluate practices was held (annual report 2014). Capacity building developed at the CHU Sanou Souro to treat patients in compliance with WHO guidelines on HIV care (annual report 2011). From my point of view this subactivity overlaps with subactivity 2.1.1, unclear.
	2.2: Complete biologic monitoring is included in the care and treatment of patients	2.2.1 Evaluate the conformity of lab regarding guidelines	National laboratory maintenance strategy and laboratory strengthening plan designed (Annual report 2012)
		2.2.2 Improve labs conformity to international standards (GLPs) and maintenance strategy implementation	System of collection of samples and VL results return implemented in 2011-2012 (annual report 2011) Purchase of laboratory equipment and material (Annual report 2012) Regional maintenance strategy drawn. (semiannual report 2013) Workshop organized to provide training on GBEA lab techniques for 25 lab staff. (semiannual report 2013) Improvement of biological follow-up of PLWHA and quality laboratory testing, but comprise due to frequent shortages of reagents. (semiannual report 2013)

		2.2.3 Technical updating of the personnel involved in PLWA biologic monitoring	Good Laboratory Practice (GLP) compliance to ensure quality lab monitoring for HIV patients assessed by twinning partnership (annual report 2011). Regional hospital biologist attended international training (Dakar, Senegal) in virology in October 2011(annual report 2011) Training of laboratory staff in biological monitoring of PLWHA (workshops, internships and international courses in Dakar) Annual report 2012 29 laboratory staff received training in biological follow up of PLWHA (semi annual report 2013) 3 biological pharmacist pursue university diplomas in retro virology (Dakar) (semi annual report 2013) 2 professionals received grants for retro virology training in Dakar, and 6 laboratory technicians received RESAOLAB training in Bamako (annual report 2014).
	2.3: Compliance of the psychosocial dimension of TCC are improved through increased community support (Improvement in access to care and treatment, compliance and a reduction in patients lost to follow-up)	2.3.1 Organization of the decentralization of the mediator model	Operational plan for decentralization of mediator's model adopted in February 2012, along with UNDP programme PAMAC (annual report 2012)
		2.3.2 Reinforcement of psycho-social capacities in treatment sites	Manuals for training of psychosocial counselors drawn in 2012 (semiannual report 2013) 20 national trainers trained. Cascade training for 50 counselors. (Semiannual report 2013) 25 psychologists trained in psychosocial supervision. (Semiannual report 2013) Tools to collect social and psychosocial data provided (annual report 2014) Supervision session organized with PAMAC by trained psychologist (annual report 2014)
		2.3.3 Reinforcement of patient treatment education (PTE) capacities	Capacity building of national trainers: 100 professionals received training on treatment education and psychosocial support by national trainers. (Annual report 2012) Yearly dialogue and awareness workshop held in Bobo to coordinate activities at TCC level (semiannual report 2013) Conciliation and awareness workshop organized with PAMAC (annual report 2014)

Output 3: Improve information systems for correlating inputs needs to consumption/coho rt data in the project area	Activity A3.1: The availability and quality of data related to medical care and treatment are improved	3.1.1 Standardize the monitoring of patients in TCC in the project zone	The medical record system for PLWHA care harmonized and 30 doctors trained on its use: reconfiguration of the care circuit for PLWHA (semiannual report 2013). Used of standardized patient file. All sites are equipped with computer software for patients monitoring (annual report 2011) All ESTHERAID sites have functional and up-to-date database (equipment available, ESOPE installed, staff trained). Annual report 2012
		3.1.2 Improvement in the quality of patients data	Evaluation officer recruited to update databases, conduct quality controls and collect indicators (annual report 2012 and semiannual report 2013). Database updating workshops (annual report 2012)
		3.1.3 Improve feedback on a regional and outlying level	Supervision missions for collection of data and quality control conducted in 2013 (semiannual report 2013). Evaluation workshop on the quality of data held (annual report 2014)
		3.1.4 Rationalize national indicators related to HIV/Aids	ESOPE software for centralizing data and monitoring indicators at national level rolled out. Training workshops were held (annual report 2014) Printing and diffusion of medical records (annual report 2014)
	Activity A3.2: Availability and quality of data related to the use of inputs are better	3.2.1 Stock management tool adaptation	The initial plans to implement a computerized management and dispensing ARV tool were abandoned in favor of the initiative to strength skills on the use of simplified tools (excel sheet/paper tools) (annual report 2012, midterm evaluation report page 20) Drawing up user and technical specifications by an international technical team to support the extension of software CHANNEL (semiannual report 2013) A taskforce comprising institutions, users and ESTHER experts was set to hire and monitor the local development of a software programme by a Burkinabe Software
		3.2.2 Deploy the integrated drugs management software at peripheral level (regions of the project zone)	
		3.2.3 Update the stock management software for lab reagents	

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Annex 7

Questionnaire for Burkina Faso
(in French)

Questionnaire Evaluation finale Projet ESTHERAID - BURKINA FASO

Les questions ci-dessous portent essentiellement sur la pérennisation du Projet, c'est-à-dire sur ses réalisations à moyen et long terme, après la fin officielle du Projet ESTHERAID en 2014. A l'exception de deux questions ouvertes, il n'y a qu'à choisir entre les réponses prédéfinies, et un bref commentaire est demandé lorsque c'est nécessaire.

QUESTIONS	RÉPONSES Veuillez cocher la case en regard de la réponse.	COMMENTAIRES
1. RENFORCEMENT DE LA GESTION DES MÉDICAMENTS		
1.1 Est-ce que le comité de quantification des médicaments (en anglais 'Supply Management Committee'), qui inclut les partenaires et bailleurs) se réunit encore régulièrement depuis 2014?	[ ] oui, régulièrement [ ] irrégulièrement (dans ce cas, veuillez expliquer par un bref commentaire ci-contre). [ ] plus du tout (veuillez expliquer brièvement ci-contre).	
1.2 Est-ce que les activités du système de pharmacovigilance mis en place avec l'appui du Projet continuent depuis 2014?	[ ] oui. [ ] irrégulièrement (dans ce cas, veuillez expliquer par un bref commentaire ci-contre). [ ] plus du tout (veuillez expliquer brièvement ci-contre).	
1.3 Les **4** pharmaciens ayant bénéficié d'une bourse pour un DIU en 2014 sont-ils encore actifs à leur poste ou à un poste qui correspond à leur formation?	[ ] oui. Trois ou quatre d'entre eux sont toujours en poste. [ ] non. Au moins deux d'entre eux ont quitté leur poste pour un autre qui ne correspond plus à leur formation (dans ce cas, veuillez expliquer ci-contre).	
1.4 Le logiciel de gestion des stocks de médicaments GESDIS, prévu dans les pharmacies de 8 sites de traitement, n'était pas encore disponible à la fin du Projet. Est-ce que ce logiciel a été rendu opérationnel en 2015 avec le soutien d'ESTHERGAS ou d'un autre bailleur?	[ ] oui, dans au moins 6 des sites. [ ] partiellement. Il s'utilise dans moins de 4 sites (veuillez justifier brièvement). [ ] pas du tout (veuillez justifier brièvement).	
1.5 Le logiciel GESDIS a-t-il été déployé dans des sites au dehors de la zone du Projet ESTHERAID avec l'appui d'ESTHERGAS ou d'un autre bailleur?	[ ] oui. [ ] non. (Veuillez justifier brièvement.)	

1.6 Qu'est-ce que le partenariat avec l'ACAME apporte aujourd'hui à la centrale d'achat du Burkina Faso?	(Question ouverte)	
1.7 Est-ce que les guides de bonnes pratiques et les manuels de gestion des stocks distribués par ESTHERAID au niveau central et dans les sites périphériques sont encore disponibles (en version papier ou sous forme électronique)?	[ ] oui, dans tous les sites ou au moins 75% d'entre eux. [ ] non; on les trouve dans moins de 75% des sites.	
1.8 Est-ce que des ruptures de stocks d'ARVs (1 semaine ou plus) ont été observées dans un ou plusieurs des sites depuis la fin du Projet en 2014?	[ ] oui. (Si oui, expliquez brièvement.) [ ] non	
2. DISPONIBILITÉ DE L'APPUI AUX LABORATOIRES		
2.1 Les **2** professionnels formés en rétrovirologie à Dakar et les **6** techniciens formés en RESAOLAB à Bamako sont-ils encore actifs (à leur poste d'origine ou à un poste équivalent)?	[ ] oui. Au moins 6 d'entre eux sont en poste. [ ] non. Moins de 4 sont encore à leur poste. Les autres ont été affectés à un poste non équivalent à leur formation (dans ce cas, veuillez expliquer ci-contre).	
2.2 Est-ce que le Contrôle de Qualité (CQ) des tests VIH (test rapide, CD4, charge virale) par le LNR continue de se faire depuis 2014?	[ ] oui, régulièrement [ ] irrégulièrement (dans ce cas, veuillez expliquer par un bref commentaire ci-contre). [ ] plus du tout (veuillez expliquer brièvement ci-contre).	
2.3 Est-ce que les **8** techniciens de laboratoire formés en Assurance Qualité à Bamako (Fondation Mérieux) sont encore à leur poste ou à un poste équivalent?	[ ] oui. Au moins 5 d'entre eux sont en poste. [ ] non. Quatre techniciens ou moins sont encore à leur poste. Les autres ont été affectés à un poste qui n'est plus équivalent à leur formation (dans ce cas, veuillez expliquer ci-contre).	
2.4 Le logiciel de gestion des échantillons pour la charge virale ainsi que des résultats est-il encore utilisé partout où il a été installé?	[ ] oui, dans au moins 75% des sites. [ ] non; il s'utilise dans moins de 75% sites (veuillez justifier brièvement). [ ] plus du tout (veuillez justifier brièvement).	
2.5 Est-ce que le Fonds Mondial a financé la maintenance des équipements de mesure de la charge virale depuis la fin du Projet en 2014 (comme c'était prévu)?	[ ] oui, dans tous ou presque tous (75%) les sites. [ ] non. (Dans ce cas, expliquez brièvement.)	

3. PRISE EN CHARGE DES PATIENTS VIH		
3.1 Le rapport annuel 2014, considéré comme rapport final, indique que 426 patients étaient traités aux ARVs de deuxième ligne en septembre 2014. Quel était leur nombre à la fin de 2015?	(Question ouverte)	
3.2 Est-ce que les comités thérapeutiques mis en place dans les sites appuyés par le Projet continuent de se réunir depuis la fin du Projet en 2014?	[ ] oui, régulièrement [ ] irrégulièrement (dans ce cas, veuillez expliquer par un bref commentaire ci-contre). [ ] plus du tout (veuillez expliquer brièvement ci-contre).	
3.3 Les **3** prescripteurs formés à Ouagadougou (DIU 2014) sont-ils encore actifs (à leur poste d'origine ou à un poste équivalent)?	[ ] oui. Au moins 2 des 3 sont en poste. [ ] non. 0 ou 1 seul est encore à son poste. Les autres ont été affectés à un poste qui n'est plus équivalent à leur formation (dans ce cas, veuillez expliquer ci-contre).	
3.4 Les agents de santé formés sur place à la prise en charge des patients sont-ils encore actifs (à leur poste d'origine ou à un poste équivalent)?	[ ] oui. Au moins les trois-quarts sont encore en poste. [ ] partiellement. Entre la moitié et les trois-quarts sont encore en poste. [ ] non. Moins de la moitié d'entre eux sont encore à leur poste ou à un poste équivalent. (dans ce cas, veuillez expliquer ci-contre).	
4. ACTIVITÉS COMMUNAUTAIRES		
4.1 L'appui communautaire est-il financé par un autre bailleur (p.ex. le Fonds Mondial) depuis la fin du Projet? (Appui communautaire = éducation nutritionnelle, appui à l'observance et groupes de PVVIH.)	[ ] oui, en totalité ou en grande partie. [ ] non. Le financement est irrégulier ou totalement interrompu. (Veuillez expliquer brièvement pourquoi.)	
4.2 La recherche des perdus de vue (PDV) est-elle financée par un autre bailleur (p.ex. le Fonds Mondial) depuis la fin du Projet en 2014?	[ ] oui, en totalité ou en grande partie. [ ] non. Le financement de l'activité est irrégulier ou totalement interrompu. (Veuillez expliquer brièvement pourquoi.)	

5. COLLECTE DE DONNÉES AVEC ESOPE		
5.1 Est-ce que le logiciel ESOPE continue d'être utilisé dans les sites où il a été mise en place avant la fin du Projet?	[ ] oui, dans au moins 75% des sites. [ ] partiellement; il s'utilise dans moins de 75% sites (veuillez expliquer brièvement pourquoi). [ ] non, plus du tout (veuillez expliquer brièvement pourquoi).	
5.2 Dans les sites où ESOPE est encore utilisé, la base de données est-elle à jour? Autrement dit, le nombre de patients dans la file active est-il comparable au nombre obtenu par d'autres méthodes (p.ex. en consultant les registres de consultation)?	[ ] oui, la concordance est bonne. [ ] non, la base de données d'ESOPE n'est pas à jour, car la saisie ne se fait pas/plus régulièrement en raison de problèmes de personnel, problèmes techniques, etc. (Dans ce cas, veuillez ajouter un bref commentaire)	
5.3 Le PSSLS a-t-il pu assurer la maintenance d'ESOPE depuis la fin du Projet, comme prévu?	[ ] oui, sans difficulté majeure. [ ] non. (Dans ce cas, veuillez expliquer brièvement.)	
6. MAINTIEN DU NIVEAU DE COMPÉTENCE DES EFFECTIFS AU FIL DU TEMPS		
6.1 Le Projet prévoyait des formations de formateurs et des formations en cascade pour maintenir le niveau de compétence des effectifs en cas de départ des premiers formés. Ces formations de remplacement ont-elles eu lieu depuis fin 2014?	[ ] oui, lorsque c'était nécessaire. [ ] non. (Dans ce cas, veuillez brièvement en donner la raison.)	
6.2 Les supervisions formatives trimestrielles mises en place durant le Projet continuent-elles de se faire après 2014?	[ ] oui, (assez) régulièrement [ ] irrégulièrement (dans ce cas, veuillez expliquer brièvement pourquoi). [ ] non, plus du tout (dans ce cas, veuillez expliquer par un bref commentaire ci-contre).	
6.3 Les nombreux manuels de référence, développés, imprimés et distribués avec l'appui du Projet, sont-ils encore disponibles depuis 2014 dans les sites où ils avaient été déposés, en version papier ou version électronique?	[ ] oui, dans au moins 75% des endroits où ils doivent normalement se trouver. [ ] partiellement; on les trouve dans 50 à 75% des sites (veuillez expliquer brièvement pourquoi). [ ] non. On les retrouve dans moins de la moitié des sites.	

7. BILAN FINAL (SUBJECTIF)	
7.1 A votre avis, quels furent les trois points forts du projet ESTHERAID au Burkina Faso ?	Question ouverte. Il n'est pas nécessaire d'entrer dans les détails. 1) 2) 3)
7.2 A votre avis, quels furent les points faibles du Projet ESTHERAID au Burkina Faso ?	Question ouverte. Il n'est pas nécessaire d'entrer dans les détails. 1) 2) 3)

NOM DE L'ACTEUR/ACTRICE AYANT RÉPONDU :
FONCTION EXERCÉE AU SEIN DU PROJET :
DATE :

Merci beaucoup de votre collaboration à cette évaluation.

Annex 8

Limited evidence about sustainability in the five countries

LIMITED EVIDENCE ABOUT SUSTAINABILITY

	BENIN	**BURKINA FASO** (Only 2nd line ART)	**CAMEROON**	**CAR** (Only paediatric ART)	**MALI**
- Nb of children under paediatric ART	803 children reported in Sep14; 826 reported in Dec15.		1748 children reported in Sep14; data 2015 not requested during visit; not found on Internet	739 children reported in Sep14; 1112 reported in Dec15[1].	1717 children reported in Sep14; 2447 reported in Dec15.
- Nb of adults and children under 2nd line ART	544 reported in Sep14; 487 reported in Dec15.	426 reported in Sep14; 370 reported in Dec15.	3423 reported in Sep14; data not requested during visit; not found on Internet		2140 reported in Sep14; 2781 reported in Dec15.
Stock-outs in project area since 2014	No stock-outs reported by 1 key informant	1 site reported no stock-outs. No feedback for other sites.	Data not requested during country visit. Not found on Internet.	ARVs available at visited sites in Bangui through TGF grant.	Several ARV stock-outs reported since end 2014, but no stock-outs reported of laboratory reagents.
PSM	- HIV quantification sub-committee meets irregularly. - Stock mgt tools still in use. But software MEDISTOCK not yet operational; "to be piloted in 2016". - Most stock managers still in their position	- HIV quantification sub-committee meets regularly. - Pharmacovigilance system is operational. - 2 out of the 4 pharmacists trained abroad still hold their position - GESDIS stock mgt software available in 18 sites in country - Stock mgt manuals still available at most sites	- HIV quantification committees kept going on thru 2015, but now under threat because of no funding. - Under GF programme, all procurement through PPM; CENAME only responsible for storage and distribution. - VINDATA ARV distribution software promoted by ESTHER-AID to replace MEDISTOCK, unavailable until end project. - Planned to be installed in ± 17 sites by 2017 with support of TGF and CNLS's approval. - Staff in charge of ARV distribution to PLHIV at one site completely overloaded; better at two remaining sites, but waiting time too long.	- Pharmacies at two peripheral sites performing adequately. - PSM data collected on paper tools	- Most or all 8 pharmacists are in the same position - Supervision visits are irregular, but multidisciplinary supervision manual still used - Stock mgt and ARV dispensation manuals still used

(1) Data provided by doctor in charge of M&E at the "Direction de la Lutte contre les Endémies Spécifiques" (DLES), Bangui. All databases in Excel.

	BENIN	BURKINA FASO	CAMEROON	CAR	MALI
LABORATORY	No feedback received from key informant in charge of laboratory issues.	- Less than 4 out of 8 professionals trained abroad still in place. - Maintenance of lab equipment for VL and CD4 supported by TGF.	- HIV test and biology supposedly free of charge. CD4 largely subsidised by MoH. - No stock-outs of CD4 reagents reported.	- Three main laboratories do only HIV testing; all other tests referred to Nat Lab or Pasteur. - Large stock of reagents for PCR machine (EID) at National Laboratory still available.	- 3 staff of the National Laboratory still in their position. - QC of ARVs still performed by National Laboratory - maintenance of equipment supported by Government
CLINICAL CASE MANAGEMENT	- About half of trained healthcare providers still in place. - ART therapeutic committees meet irregularly	- ART therapeutic committees meet irregularly. - 3 out of 3 trained healthcare providers left their position, but most trained nurses and technicians still in place[2].	- Therapeutic committee still exists at Hôpital Central, Yaoundé and in Bafoussam. - Std medical record developed and distributed to all 13 sites. Since end funding in 2015, blank record sold to PLHIV.	- At CPB, only 1 out of 6 MDs still in position - Most healthcare staff met in Begoua arrived after ESTHERAID - Std patient record developed by MoH with ESTHERAID.	- Therapeutic committees meet regularly. - 4 out of 6 healthcare professionals trained abroad still in position
COMMUNITY INTERVENTIONS	No feedback received from key informant in charge of laboratory issues.	- Several activities interrupted because of no funding. - TGF expected to support community interventions through soon-to-start NFM project, but a lot less than under ESTHERAID.	- Interventions under serious threat because of no financial support for community workers since end 2015 or earlier.	- Trained community workers have continued working since Dec14 with irregular support from various donors, but entire component under threat of collapse.	- Community interventions suffered from lack of funding during 2015 but have not been completely interrupted.
PATIENT DATA MGT. (ESOPE)	- Problems with hardware - No funding for software maintenance - No salary for data entry clerks - Some of the 10 sites still have up-to-date databases	- ESOPE said to be operational in at least 75% of sites. - Databases are up to date. - Maintenance of software by NACP	- Since Oct15, no funding for data entry, thus ESOPE in three visited sites under threat. - Databases no longer up-to-date. - No compatibility betw ESOPE and VINDATA. - Maintenance ES by MoH	- ESOPE data collection interrupted from Jan to Sep15 (lack of funds); restarted since Sep15, but completely unused by National Programme. - TGF plans to revive and extend ESOPE.	- The ESOPE software is said to work fine in 17 sites. - Maintenance firm provides irregular service. - Most data entry clerks in their position.
ACTIVITIES PERPETUATING PROJECT ACHIEVEMENTS	- Reference manuals developed by ESTHERAID available in all sites - Cascade trainings organised when necessary with support of Govt or other donors - No feedback received about formative supervision visits	- Reference manuals developed by ESTHERAID available in at least 75% of sites - No cascade trainings after 2014 - No formative supervision visits since end 2014	- Reference manuals distributed to all project treatment centres. In Bafoussam, some paper & electronic version missing. - No formative supervision visits after 2015, because no funding.	- All reference material developed by ESTHERAID looted from Begoua. - No cascade trainings ever mentioned during country visit. - Formative supervision visits continue with support from Expertise-France	- Reference manuals developed by ESTHERAID available in all sites - Cascade trainings organised when necessary with support of Govt or other donors - Formative supervision visits irregular

(2) From 2012 onwards lots of medical doctors left their position to start specialising once the Government made access to specialisation easier.