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UNITAID

Mid-Term Review

ACT Scale-up

Partners: UNICEF and The Global Fund to fight AIDS, Tuberculosis and malaria

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Abbreviations

ACT	Artemisinin based Combination Therapies
AMFm	Affordable Medicine Facility - Malaria
CCM	Country Coordinating Mechanism
FPM	Fund Portfolio Manager
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome
IL	Implementation Letter
LTA	Long Term Agreements
MoH	Ministry of Health
MoU	Memorandum of Understanding
MSH	Management Sciences for Health
OECD	Organisation for Economic Co-operation and Development
OIG	Office of the Inspector General
PR	Principal Recipient
PSM	Procurement and supplies management or mechanism
QA	Quality Assurance
RDT	Rapid diagnostic test for malaria
RFP	Request For Proposal
Swiss TPH	Swiss Tropical and Public Health Institute
SWOT	Strengths, Weaknesses, Opportunities and Threats
TB	Tuberculosis
UNICEF	United Nations Children's Fund
WAP	Weighted Average Price
WHO	World Health Organization

1 Executive Summary

Project key information

The ACT Scale-up Initiative is supported by UNITAID and carried out by the United Nations Children's Fund (UNICEF) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). The main objective of the Project (2007 to 2011) was to increase the access and affordability of Artemisinin based Combination Therapies (ACT, target of 47 million treatments) with an initial estimated budget of 78 million USD at the signature of the Memorandum of Understanding (MoU) in 2007. For this purpose, the project engaged with 11 ongoing GFATM grants in 8 countries. UNICEF was the procurement agent responsible for delivering the 47 million treatments. However, the target and budget were readjusted, In 2010, the budget decreased to 51.6 million USD and the number of patients was adjusted to 43 million. According to the MoU, the project will terminate in December 2011.

A secondary set of objectives was to decrease the lead time for drug delivery and the prevention of ACT stock-outs, to increase in the number of quality manufacturers of ACT drugs, and to achieve a continuous supply of high quality ACT at the lowest possible price.

The review period taken into account in this mid-term review spans from the signature of the MoU in November 2007 up to the 4th interim report (December 2010). The review was based on key documents, such as the MoU, the Interim and Annual Reports and Board resolutions. The evaluation looked at the relevance, effectiveness, efficiency and impact of the project using an evaluation matrix. More specific questions and a set of issues related to the financial and programmatic reporting were also addressed.

Key findings

In regards to the relevance of the project, the project design had several weaknesses, since the formulation of the objectives was not adequately defined. Additionally, several activities were related to the project management and not directly linked to the objectives. The key limitation of the project was that it was difficult to report the actual number of patients treated with UNITAID funded ACT. Therefore, it was not possible to accurately estimate the achievement of the key objective of the project.

However, to assess the effectiveness of the project, the number of ACT delivered by UNITAID could be used as a proxy for the number of patients who received UNITAID funded ACT. At the time of the review, 28,5 million, i.e. 65% of the ACT, had been delivered, with 15 million still to be delivered before the end of the project in December 2011.

Channelling UNITAID funding through the GFATM Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) grants made it possible to build upon existing systems and ensured that funding was going towards well-performing grants. However it was also contributed to slower achievement of the objectives, due to the complexity of the grant management system and the need to align to the lifecycle of the selected grants.

For the procurement-related objectives, lead time was reduced from 3.6 to 2.1 months between years 1 to 3 and no stock-outs were reported. Thirty manufacturers participated in three RFP tenders and eight companies signed a Long Term Agreement (LTA) with UNICEF for supplying ACT. For the period 2007-2008, two new sources of ACT received WHO pre-qualification, whereas the 2nd and 3rd Annual Reports respectively mentioned 7 and 1 new formulations that obtained WHO pre-qualification. The procurement strategy has been efficiently handled by UNICEF: weighted average price for most of the items was below the international median price. However, achievements also depended on external market variables, such as other donors' contributions (GFATM, USAID/PMI, World Bank),

supplier priorities, local or global health recommendations, Minister of Health Policies, ACT demand and absorption by each participating country in which UNICEF/GFATM have little influence. Therefore, they cannot be fully attributed to the project.

According to the GFATM, availability of ACT has increased dramatically. Worldwide, the number of treatment courses procured increased from just over 11 million in 2005 to 158 million in 2009. In 2010, the GFATM estimated that 170 million treatments were procured[1]. At the same time, the World Bank booster program (2005-2008) provided 42 million ACT treatments, and the USAID/PMI annual report for 2010 indicates that between 2006-2010, 93.3 Mio treatments were procured out of which 63.5 Mio were distributed[2]. In view of these figures, the project contribution appears to be limited as the ACT funded by UNITAID represent 16.7% of total treatments distributed by the GFATM. Compared to the target for 2010, the overall UNITAID contribution represents 10.8% of the GFATM/PMI activity, and when adding the World Bank Booster program, the UNITAID contribution corresponds to 9.3% of all ACT treatments funded.
Thus the market impact was limited. Although the approach of pairing a donor with a procurement agent was innovative, the implementation of the program itself was a challenge and numerous amendments were necessary, which lead to limited achievements.

Concerning the impact the project had on the health status of the populations, the annual reports did not allow for the estimation of the extent of support provided by UNITAID: for example, reports contained no information on child and adult morbidity and mortality in the countries where ACT were delivered, nor on under-five malaria morbidity trends.

The overall budget execution for the period was 71%. Most of the funds were disbursed upfront to UNICEF (42% of all funds disbursed in the first 6 months). The actual spending of the funds by UNICEF to procure ACT treatment was slower and reached 56% of the total budget by the end of 2010. During the whole period a significant amount of funds were held by UNICEF, and no interests earned were reported.

The evaluation team noticed the poor archiving system, which made it difficult to locate the different documents. The MoU did not include UNITAID validation and clarification processes for interim and annual reports nor did it include standardized reporting templates for the financial and programmatic reports. Budget adjustments and reallocations were not systematically formalised in amendments to the initial MoU that was officially approved by all parties.

Key recommendations

- UNITAID should maintain its efforts to reach the targets of the project until the end of 2011.
- In the future, UNITAID should consider channelling its funds through more efficient implementation arrangements (e.g. increasing its contribution to AMFm, after more evidence is available from the pilot phase)
- When working with Global Fund grants, UNITAID should set up a tool to follow-up on important changes in the grants implementation at the Global Fund level.
- UNITAID's partners should report on interests earned, which are to be reallocated to the project or deducted from the next disbursement.
- Together with implementing partners, UNITAID should design a risk management plan for this project that notably addresses phasing out of the project.

[1] The Global FUnd : http://www.theglobalfund.org/en/about/diseases/malaria/
[2] The President's Malaria Initiative Fifth Annual Report to Congress April 2011

- From lessons learned, UNITAID must make sure that the key indicators of performance defined for its programs are measurable, and where data is not available, UNITAID should consider conducting surveys in sentinel sites or reviewing the indicators (e.g. measure only treatments procured, not patients treated)
- The reporting process should be improved with clear, written and standardized processes and templates and further quality checks. UNITAID should establish a common log frame template for all projects
- Market price reduction should be measured using market price reduction over time. In addition, the comparison of weighted average price paid by the project to the market price should be used to measure procurement efficiency
- A general recommendation common across all project reviews is for UNITAID to implement a document management system.

2 Objective

The Swiss Centre of International Health (SCIH) of the Swiss Tropical and Public Health Institute (Swiss TPH, formerly known as Swiss Tropical Institute – STI) was mandated to perform an independent programmatic mid-term evaluation of six UNITAID funded projects, including the "ACT Scale-Up" project implemented by UNICEF and the GFATM to fight AIDS, Tuberculosis and Malaria (GFATM).

The evaluation areas were relevance, effectiveness, efficiency and impact of the project, according to the OECD (Organisation for Economic Co-operation and Development) evaluation criteria. A key question was to define to which extent the objectives are likely to be reached by the end of the project. The evaluation is also meant to provide UNITAID with recommendations on the project management, monitoring and evaluation and project reporting. Additionally, the evaluation includes an outline of the strengths, weaknesses, opportunities and threats (SWOT) related to the project.

For this mandate, SCIH drew on its extensive experience in project monitoring and evaluation, in particular in the frame of assignments for the GFATM in 18 countries, the Global Drug Facility (GDF), and the Financial Mechanism Office (FMO), which administers the cohesion fund within the European Union financed by Norway, Iceland and Liechtenstein, among others.

SCIH has also developed capacity assessment tools for UNITAID and has piloted those tools (EXPAND-TB) together with UNITAID's partners FIND and GLI. During this project, run in 2009, SCIH has acquired a deep understanding of UNITAID projects management and familiarity with key documents and guidelines.

3 Project Description

In 2006, UNITAID funded the project "ACT Scale-Up" implemented both by the GFATM and UNICEF. The overall objective of the project is to increase access to, and affordability of high quality ACT to treat malaria. In November 2007, a MoU was signed, which established the target of delivering 47,016,160 ACT treatments by the end of 2011 in 8 countries (Cambodia, Ethiopia, Ghana, Indonesia, Madagascar, Mozambique, Sudan and Zambia), hosting 11 GFATM grants altogether. Countries were chosen on the grounds of their demonstrated prior achievements in delivering anti-malarial treatments to patients and were also identified by the GFATM as being able to manage and absorb additional ACT. The procurement strategy and delivery facility of the project were under the responsibility of UNICEF. The total budget of the project was initially 78,887,568 USD.

Roles and Responsibilities

- **UNITAID** is primarily responsible for the timely provision of funding to UNICEF for the purchasing or procurement and quality assurance of ACT. Additional responsibilities comprise the review of financial and programmatic progress of the project, the provision of strategic advice on all objectives for market incentives and stimulation of ACT price reduction;

- **UNICEF** is responsible for the procurement and timely delivery of ACT, with the constitution of a buffer stock to prevent stock-outs. Additional responsibilities include submitting interim progress reports and annual reports; engaging and negotiating with the industry to achieve lower prices and ensure the availability of ACT; ensuring compliance with the WHO prequalification procedures to encourage ACT suppliers to seek prequalification status; facilitating technical support in drug supply and management for beneficiary countries; taking actions with UNITAID and GFATM to suspend future deliveries of ACT in countries where the GFATM grant are terminated or suspended;

- **GFATM** is primarily responsible for the selection and management of funds that receive UNITAID-funded ACT. It should adjust GFATM budgets and targets to reflect UNITAID funding; monitor GFATM program results for the ACT scale-up project; submit interim and annual progress reports to UNITAID; approve Principal Recipient (PR) requests for ACT disbursements based on performance; facilitate technical support to ensure successful implementation of Project.

The process to undertake target and budget adjustments was based on individual country demands and forecasts for ACT treatments under GFATM grants. The GFATM would report to UNITAID and UNICEF any significant changes of ACT targets at the country level. Then UNICEF would propose a budget for the procurement and delivery of the necessary UNITAID-funded ACT treatments, which would be followed by an adjustment of the ACT target and budget endorsed by UNITAID Board resolutions. Consequently, in November 2008, the UNITAID board approved the reduced budget and treatment targets, and as of July 2009 the revised targets were 43,317,760 UNITAID-funded treatments with a total budget of 54,214,397 USD. Some additional budget decreases were also approved by UNITAID after the Annual Reports submission. Thus, at the time of the 3rd Annual Report, the last approved budget was 51,659,815 USD.

Item	Description
Name	ACT Scale Up
Project summary	The objective of the project is to increase access to, and affordability of High Quality Artemisinin Combination Therapies (ACT) drugs for use in malaria control
Partners	UNICEF / Global Fund
Number of countries	8
Period	2007 - 2011
Budget	US$ 51,659,815

4 Approach and methods

This is a summative, external, independent mid-term evaluation with a SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis, including recommendations based on the findings of the evaluation.

The evaluation was conducted by a main evaluator supported by a second evaluator responsible for preparing the project outline, extracting the data in the evaluation matrix and contributing to the other tasks in the evaluation process. Evaluators were supported by a financial expert, a PSM (procurement and supplies management) expert, the project leader and the project manager.

4.1 Evaluation components

The evaluation had three components: (1) evaluation of common areas to all UNITAID projects, (2) project-specific questions and (3) supporting data and quality of reporting.

(1) Common areas

The common evaluation areas have been provided in the RFP issued by UNITAID. They are compliant with the OECD evaluation criteria[3] and are defined as follows:

- **Relevance**: consistency between the activities of the project with the project plan and with UNITAID's objectives and strategy.
- **Effectiveness**: degree of achievement of the objectives of the project.
- **Efficiency**: relation between the effort invested in carrying out the activities of the project and the results of the projects, mainly in procurement.
- **Impact**: effects of the project beyond the achievement of the short-term objectives. of the project.

For each evaluation area, 'questions', 'relevant quantitative and qualitative indicators', 'sources of information' and 'analytical methods' were defined. For each indicator, sources of information were identified and the analytical methods to estimate each indicator were defined (see Annex 1- Evaluation Matrix, Table 10). Evaluation questions related to the common areas were addressed consistently across all projects to minimise the risk of bias attributable to differences in the approaches by different evaluators.

(2) Project-specific questions

UNITAID, in the RFP, proposed a series of project-specific questions. These questions were further adapted in discussions between the evaluators team and UNITAID secretariat. Finally, the questions specific to ACT Scale-up were as follows:

- Is the project implemented in the most efficient way compared to alternatives?
- Can price reductions (as opposed to cost savings) be demonstrated?
- Have effective steps towards transitioning this project to more sustainable sources of funding been taken?

The full list of the project-specific questions is found in Annex 1 - Table 10~~Table 10~~).

(3) Quality of reporting

The evaluation team was alerted by UNITAID that projects programmatic and financial reports sent to UNITAID might pose challenges in terms of their completeness, consistency across projects and with

[3] OECD DAC Network on development evaluation. Evaluation development co-operation. Summary of key norms and standards. Second edition. OECD 2010.

the MOU, and contain ambiguities in project design (e.g. confusion between 'objectives' and 'activities'). Given that the evaluation of the projects was mainly based on information contained in programmatic and financial reports it was anticipated that reporting problems could affect the findings of the evaluation.

A guiding checklist was prepared to have consistent assessments of the quality of reporting across evaluators and projects evaluated (see Table 11~~Table 11~~).

4.2 Methods

1. **Sources of information**

   The sources of information to conduct the evaluation were:

   - Memorandum of Understanding between UNITAID and the implementing partner(s) and other legal documents where appropriate;
   - Project progress reports (semi-annual or annual) submitted to UNITAID till the date when the evaluation of a given project started;
   - Financial reports;
   - Other documents, such as follow-up reports by UNITAID Secretariat, initial project proposal or financial audits.

2. **Project outline**

   A preliminary reading of project documents suggested that not all projects were consistent in terms of what was considered to be an 'objective' and an 'activity', and in the links between them. Then, the first step was to create a "project outline" that identified the key project characteristics, i.e.:

   - Project objectives,
   - Project targets against which to measure the achievements of objectives,
   - Activities and timelines for each activity,
   - Procurement plan and
   - Budget and disbursement plan.

   Any additional information deemed useful in understanding the project was retrieved for the evaluation and reported into the project outline. For example, any changes in the objectives or in the number of beneficiary countries were mentioned in the project outline. This "project outline" was based on existing literature[4] that addressed a logical framework.

   Key definitions to be applicable in each project were also defined to make the nature of the information collected consistent:

   - An objective was defined as a statement that described what should be achieved at certain points in time and/or at the end of the project;
   - An activity was defined as a description of the events that should occur in certain times and places and involve certain people. Where possible, activities were linked to objectives, either based on the information contained in the reports or on the judgment of the evaluators.

3. **Data sources and extraction**

   Information was extracted from interim and annual reports submitted to UNITAID by UNICEF and the GFATM and from UNITAID board reports and resolutions. The reports included were

[4] Nacholas S. How to do (or not to do)… A Logical Framework. Health Policy and Planning 1998; 13(2): 189-93.

four interim reports: December 2007, July to December 2008, July to December 2009 and July to December 2010; and three annual reports: December 2007 to June 2008, July 2008 to June 2009 and July 2009 to June 2010. Outcomes were extracted from the latest progress report available (December 2010) and from information compiled in the project outline.

Based on the project outline, documents included in the evaluation were scrutinised to extract the relevant data for the evaluation. A matrix evaluation addressing the three components of the mid term review was filled in and additional tables were added to summarize key findings when necessary. The matrix evaluation in Annex 1 provides:

- The core evaluation questions organized by relevance, effectiveness, efficiency and impact
- The questions specific to the ACT Scale-up project
- The reporting questions common to all UNITAID project. .

For the market information, the evaluation team relied on publicly available information on drugs and diagnostics market for HIV/AIDS, Tuberculosis (TB) and Malaria. This included the WHO list of pre-qualified suppliers, drugs and diagnostics and MSH (Management Sciences for Health) drug price indicators.

Lead time is defined as the number of days between the date a purchase order is issued for a specific item and the date of the item's arrival in the country.

UNITAID portfolio managers and implementing partners were contacted to clarify issues related to the availability and quality of data (see Annex 2).

4. Analysis

The evaluation in each area was a composite of the evaluation of each question based on the indicators, as defined in the evaluation matrix. In the analysis, quantitative indicators were calculated and qualitative indicators formulated. When information to estimate indicators was missing, it was made explicit in order to avoid confounding missing indicators with poor performance.

The evaluation of each area was accompanied by an assessment of the quality of the underlying data. Data was considered of poor quality when it was partial (e.g. describing what happened in one country but not in another), when sources were not indicated or when there were obvious inconsistencies not attributable to project performance (e.g. different figures for the same event in different reports).
When data is missing or of poor quality in a given evaluation area, not much confidence can be placed in the evaluation's ability to reflect the real situation of the project. On the contrary, when quality issues are minimal, the results of the evaluation can be reasonably trusted. The quality of the underlying data is explicitly described alongside the evaluation findings.

Efforts have been made to provide explanations to the findings, based on available data (i.e. reasons for success and failure). This was discussed during a meeting between all evaluators and the project leaders to review the findings of the evaluations. The review process included discussing the project outline, the indicators and the data analysis. Where necessary, findings were fine-tuned to reflect the status of the project and to limit those aspects that could be seen as subjective. Where data was deemed insufficient to provide reliable explanations, no attempt was made to extrapolate from other projects or to speculate based on anecdotal evidence.

A rating was attached to each common evaluation area. The rating was qualitative and based on a consensus within the team of evaluators, which included the evaluators of other projects.

The rating had two parts: the rating of the evaluation area and an assessment of the quality of the underlying data. For a guide to the rating scale and an interpretation of the different categories (see Table 1~~Table 1~~).

Table 1. Rating of evaluation areas and quality of data.

	Definition	Interpretation
Rating scale		
Good performance	All indicators showed acceptable or positive results, according to the targets set	The project works as expected
Some concerns	Most of the indicators showed acceptable or positive results, but there were isolated cases where indicators suggested poor performance	The project needs minor adjustments to improve its performance or a further evaluation focusing on certain areas may be needed
Serious concerns	Most of the indicators showed poor performance.	The project needs important adjustments to improve its performance
Quality of data		
Good quality	Data to estimate all indicators was available without obvious inconsistencies	The rating reasonably reflects the true performance of the project
Moderate quality	Some data was missing or inconsistent, but most of the indicators could be estimated	It is possible that additional data might change the rating of the project
Poor quality	Most of the data was missing or inconsistent and only one or two indicators could be estimated	There is major uncertainty about the extent to which the rating reflects the true performance of the project

5. **Validation exchanges with key stakeholders**

   Preliminary findings were shared and discussed with UNITAID secretariat and the implementation partners. The aim of this exchange was to identify factual errors, to seek consensus on the findings in order to promote ownership of them, and to tailor the recommendations to the real needs of the project. Preliminary findings were sent in advance.

6. **Suggestions for a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis**

   The analysis of project strengths, weaknesses, opportunities and threats was filled based on the analysis done along the evaluation matrix, differentiating internal factors that favour/hinder the implementation of the project (strengths, weaknesses) and external factors (opportunities/threats). It is a summary of the key factors influencing the achievement of the project's objectives.

   Rather than being a formal fully-fledged SWOT analysis, the items identified in the frame of this mid-term evaluation are proposed to be considered in a formal SWOT analysis of the project, in case such an analysis is undertaken.

7. **Issuing of recommendations**

   Recommendations were issued by consensus of the team of evaluators involved in all projects. This allowed for a comprehensive overview of the issues encountered in the different projects and harmonized the recommendations. Separate recommendations were made for each project based on the findings of the evaluation, although some were common to several projects. Recommendations prioritised what was understood as the critical issues in each evaluation area and across all areas. Several options to address the critical issues were listed

and assessed against two main criteria: (a) the available evidence that proved recommendations would effectively address the critical issue identified; and (b) the feasibility of implementing the recommendation. Evidence was drawn from research, best practices or colloquial evidence (e.g. personal experience, informal evidence). Recommendations were addressed both to UNITAID and to the implementing partners.

4.3 Project specific

Outstanding issues were discussed and validated with key stakeholders and a series of questions were developed to guide interviews with the UNITAID, the GFATM, and UNICEF project managers (see Annex 2: Meetings with Stakeholders, Questions and List of Persons InterviewedAnnex 2: Meetings with Stakeholders, Questions and List of Persons Interviewed).

Following the interviews, requests for missing or needed documents were issued. Further clarification on reporting to UNITAID were obtained, including reporting templates, risk plans, consequences of the GFATM grading of grants, management issues in UNICEF and the GFATM, sources of funding for training, as well as information gathered from the customer satisfactory survey.

5 Findings

This section is based on the data following the evaluation matrix template (Annex 1). A summary of key findings is provided for each area in the boxes at the beginning of each section.

5.1 Relevance

This section reports on the assessment of whether activities implemented by the project are consistent with the initial project plan and in line with UNITAID objectives and strategy.

Rating		**Quality of supporting information**	
☐	Good performance	☐	Good
☒	Some concerns	☒	Moderate
☐	Major concerns	☐	Poor

Key findings:

- Twelve activities were defined in the MoU: three managerial and nine related to project objectives.
- The overall objective did not have a specific indicator that distinguished between UNITAID funded achievements and contributions from other stakeholders. The other three specific objectives had appropriate indicators.

Are the activities and expected outputs of the project consistent with the objectives and expected outcomes as described in the project plan?

This project is articulated around four objectives and 12 activities. One of the four objectives refers to the overall goal of the project ("scale up the number of patients accessing and receiving ACT treatment") and the other three specific objectives are related to procurement and supply management.

The overall goal of the project had no indicator that could distinguish between patients treated with UNITAID funded ACT and those treated with ACT from other sources. The first annual report states that "*The GFATM shall report on progress towards reaching the scaled-up ACT treatment targets, i.e. number of people treated with ACT*"; however, it is not indicated whether this specifically concerns UNITAID funded ACT or all ACT. On the progress reports, it appears that this indicator includes patients treated with ACT from other funding sources. Therefore, the specific contribution of UNITAID funding to the total number of ACT cannot be estimated. The degree of achievement of the three specific objectives could be estimated using appropriate indicators and was timely reported.

Table 2. Objectives and activities of the project.

	Objectives		Activities(*)
1	Scale up the number of patients accessing and receiving ACT treatment		(It has no specific activities linked to it because this is the overall goal of the project and it is assumed that it will be achieved to the same extent as the other three objectives)
2	Decrease the drug delivery lead times and prevent stock-outs	5.3	Development of procurement strategy
		5.5	Provision of forecasts and treatment targets
		5.7	Annual shipping schedule confirmed with beneficiary countries
		5.8	Placement of purchase orders and delivery
		5.9	Buffer stock arrangement
3	Increase the number of quality manufacturers and products	5.4	Engage and negotiate with industry to stimulate an increase in the availability of ACT of quality and collaborate with the WHO prequalification program to encourage prequalification of ACT
		5.6	Tendering and long term agreements with suppliers of ACT
4	Achieve continuous supply of high quality ACT at the best possible price and facilitate price reduction	5.3	Development of procurement strategy
		5.4	Engage and negotiate with industry to stimulate an increase in the availability of ACT of quality and collaborate with the WHO prequalification program to encourage prequalification of ACT
		5.6	Tendering and long term agreements with suppliers of ACT

(*) Activities can be repeated because one activity may contribute to more than one objective.

Table 2~~Table 2~~ shows the objectives of the project and the activities linked to them. All activities could be linked with at least one objective and some activities would contribute to more than one objective. Indicators attached to activities could be process or output indicators. For example, for activity 9 (buffer stock arrangement), the first milestone was to have an adequate buffer stock arrangement in place (a process indicator) and the also the number of stock-outs due to delivery delays (an output indicator).

Five of the 12 activities mentioned in the MoU are project management tasks and therefore support the implementation of the project, rather than specifically contribute to the achievements of the objectives. Thus, these activities are not included in the Table 2~~Table 2~~:

- 5.1 selection of recipients and determination of treatment targets
- 5.2 signature of agreements with beneficiary programmes
- 5.10 identification of implementation requirements
- 5.11 monitoring and evaluation
- 5.12 reporting.

The degree of implementation of activities was only partially assessed due to the lack of relevant information. Additionally, various unplanned activities were undertaken, such as health workers training:

- from December 2007 to June 2008, North Sudan supported 15 state Ministries in building the capacity of health staff on malaria control by training 900 health staff, 90 pharmacists and 30 statistical clerks on the drug policy, among other activities
- in Ghana, part of UNICEF resources were used to train 6,362 Community-Based Agents in the management of malaria at the community level and in the distribution of pre-packed ACT

- in Madagascar some additional activities included the training of health workers, the equipment of 45 health facilities and the development of project management tools.
- in North Sudan, as reported in the 2nd Annual Report, UNICEF supported microscopy training of 786 malaria technicians on proper malaria diagnosis
- in Zambia 15 mid-level staff were trained on advanced topics; UNICEF has also supported the MoH by providing non-financial incentives to community health workers in home management of malaria.

Is it possible to show how the project has contributed to UNITAID's overall goal of using innovative, global-market based approaches to improve public health by increasing access to quality products to treat, diagnose and prevent HIV/AIDS, tuberculosis and malaria?

The UNICEF procurement strategy was developed, implemented, and three rounds of supplier/manufacturer selection processes were performed to UNITAID satisfaction.
On the delivery side, according to UNICEF website[5], the amount of treatments distributed reached 28,5 million treatments for the three years (from April 2008 to December 2010) (see Table 4~~Table 4~~ for the number of treatments delivered by country).

Since the GFATM was created, 210 million treatments were delivered[6]. Availability of the ACT has also risen dramatically. Worldwide, the number of treatment courses procured increased from just over 11 million in 2005 to 158 million in 2009, and reached 170 millions by 2010 (PMI and GFATM contribution). At the same time, the World Bank Booster program (2005-2008) anticipated providing 42 million ACT treatments.

Although the approach of pairing a donor and a procurement agent was innovative, the implementation of the program was a challenge that required numerous amendments, though with limited achievements.
UNITAID is funding UNICEF for the in-country Principal Recipients (PRs) who procure medicine. The same PRs also receive funding for medicines from their GFATM grant budget (UNITAID funding "additional treatment"), which increases risk of duplication. Furthermore, the PR performance is also measured by their financial absorption rate, thus favouring spending via the grant instead of direct procurement via UNICEF.

When looking at figures from the annual reports, the project contribution appears to be limited as the ACT funded by UNITAID represent 16.7% of the overall number of treatments distributed by the GFATM in the same period (the figure of 210 millions does include non ACT treatment). When comparing with the target for 2010, the overall UNITAID contribution represents 10.8% of the GFATM-PMI[7] activity, and when considering the World Bank, the UNITAID contribution corresponds to 9.3%.

[5] UNICEF Procurement division: http://www.unicef.org/supply/index_42657.html
[6] The Global Fund : http://www.theglobalfund.org/en/about/diseases/malaria/
[7] The President's Malaria Initiative Fifth Annual Report to Congress April 2011

5.2 Effectiveness

This section assesses whether objectives of the project have been achieved, and what are the factors for achievement or non-achievement of those objectives.

Rating		Quality of supporting information	
☒	Good performance	☒	Good
☐	Some concerns	☐	Moderate
☐	Major concerns	☐	Poor

Key findings:

- According to UNICEF Procurement Division, 28,5 million ACT treatments have been delivered in a three years period (65% of the 43 million targeted) and a further 15 million will have to be delivered by the end of 2011, to meet the target. This appears to be feasible with limited additional effort.
- Lead time was reduced by 58%, from 3.6 months to 2.1 months between years 1 and 3.
- No stock-outs have been reported.
- 30 manufacturers have participated in three tenders and eight companies have signed LTA for ACT procurement with UNICEF.
- The prices of ACT decreased by 3.6% between years 1 and 2.

To what extent were the objectives of the project achieved?

At the inception of the project, collecting information on the UNITAID specific contribution to the number of patients treated with ACT was not planned. The number of patients treated, as reported by the GFATM grants, included patients treated with ACT from all sources of funding. Therefore, the only proxy for the number of treated patients with UNITAID funding is the number of ACT delivered in the countries.

Table 3~~Table 3~~ shows the number of ACT delivered up to December 2010 and the gap in order to meet the targets until the end of 2011. UNITAID delivered 65% of its target for the period, while GFATM/UNITAID delivered 66% of their consolidated target for the same period. This suggests that UNITAID and GFATM have a similar pace of activities in procuring / delivering ACT treatments

Table 3. Delivery of ACT compared with targets.

November 2007 to December 2010	Latest target	Delivered (percentage)		Gap until end of 2011
Only UNITAID	43,317,760	28,322,540	(65%)	14,995,220
UNITAID and GFATM combined	82,509,485	54,484,042	(66%)	28,025,443

Source: 4th Interim Report, Annexes 2 and 3 (for UNITAID and GFATM combined)
http://www.unicef.org/supply/index_42657.html (for UNITAID only)

The following table unfolds the number of treatments delivered by country according to information provided through UNICEF website.

Table 4 . Number of treatments delivered by country and by year.

Country / PR	Year 1	Year 2	Year 3	Total
Cambodia – PSI	-	216,000	-	216,000
Cambodia – CNM	-	79,850	-	79,850
Ghana	1,350,000	1,440,020	-	2,790,020
Mozambique	300,960	4,599,990	4,599,990	9,500,940
Sudan	-	1,434,425	1,575,000	3,009,425
Zambia – CHAZ	-	952,530	2,166,960	3,119,490
Zambia MoH	-	-	1,967,670	1,967,670
Madagascar – PSI	1,019,893	-	1,010,000	2,029,893
Madagascar – CRESAN	1,469,912	-	-	1,469,912
Indonesia	139,350	-	-	139,350
Ethiopia	-	-	3,999,990	3,999,990
Total	4'280'115	8,722,815	15'319'610	**28,322,540**

Source: http://www.unicef.org/supply/index_42657.html

Mozambique is the country that has delivered the highest number of treatments since the project started, at 33% of the total number delivered (9.5 million). By contrast, only 139,350 treatments were delivered in Indonesia using UNITAID funding with no UNICEF products delivered in Indonesia in year 2 and 3.

The overall drugs lead time Table 5~~Table 5~~) decreased from 108 days (i.e. 3.6 months) in year 1 to 63 days (i.e. 2.1 months) in year 3, i.e. 42%. Since there was no quantitative target established for this indicator in the MoU, it was not possible to estimate the level of achievement. In the first year, higher lead times were mainly attributed to delays in delivery to Madagascar for both grants. Decreasing the lead time to 63 days can be considered satisfactory. However, since this is a direct procurement (Principal Recipients procure directly from UNICEF without tendering), one could expect a greater decrease in lead time.

Moreover, when looking at the average gap between estimated and actual drug arrivals, it appears that for many countries, drugs often arrived earlier than anticipated.

Table 5. Average lead time per country

Year	Country	Average lead time (days)	Average gap between estimated and actual arrival in the country (days)
1	Madagascar (PSI)	255	21 (delay)
	Indonesia	27	45 (in advance)
	Madagascar (CRESAN)	165	24 (in advance)
	Mozambique	42	6 (in advance)
	Ghana	57	12 (in advance)
	Overall for the period	**108**	**21.5 (in advance)**
2	Mozambique	87	15 (delay)
	Ghana	99	17.5 (delay)
	Cambodia	93	15.5 (in advance)
	North Sudan	72	36 (in advance)
	Zambia	60	6 (delay)
	Overall for the period	**84**	**13 (in advance)**
3	Zambia Chaz	39	38.5 (in advance)
	Zambia MoH	63	12.3 (delay)
	Mozambique	78	12 (in advance)
	Ethiopia	51	4.8 (in advance)
	Madagascar PSI	NA	NA
	North Sudan	NA	NA
	Overall for the period	**63**	**10.8 (in advance)**
Whole period	**All countries**	**81**	**9.6 (in advance)**

Source: 3rd Annual Report, Annex 7

No days where stock-outs occurred have been reported during the period.

Thirty manufacturers participated in three tenders, and eight companies signed long LTA for ACT procurement with UNICEF. At least one new product became pre-qualified by WHO during the project period. As no targets were set in the MoU, it was not possible to estimate the level of achievement.

The price of ACT procured was reduced by 22.2% and 5.9% for some products: Arthemeter-lumefrantine from Novartis, Ajanta, Cipla, Ipca, and AS/AQ from Cipla, Ipca, Guilin, and Strides). Another ACT product price (AS/SP from Guilin and CIPLA) increased from 0.56 USD to 0.58 USD (3.6%). Table 6~~Table 6~~ shows the price changes over the three year period for individual products. The prices changes are measured through the WAP.

Table 6. Price changes over the three years.

Product	Year 1			Year 2			Year 3		
	WAP paid (*)	Budget price	Δ (%) (+)	WAP paid	Budget price	Δ (%)	WAP paid	Budget price	Δ (%)
A+L20mg+120mg tab, 6s	0.4	0.5	17.8	0.4	0.4	15.9	0.4	0.4	0.0
A+L20mg+120mg tab, 12s	0.7	0.9	17.8	0.7	0.8	8.6	0.7	0.7	0.0
A+L20mg+120mg tab, 18s	1.1	1.4	17.8	1.1	1.2	5.9	1.1	1.1	1.9
A+L20mg+120mg tab, 24s	1.4	1.8	22.2	1.4	1.6	10.3	1.3	1.3	0.0
AS 50mg+SP 525mgco-bl, tab/6+2	.	.	.	0.6	0.7	20.0	0.6	0.6	3.3
AS 100mg+SP 525mgco-bl, tab/6+3	.	.	.	1.0	1.2	14.8	1.0	1.0	2.9
AS 50mg+AQ 153mg co-bl. Tab/3+3	0.2	0.4	45.0	0.2	0.4	36.8	0.2	0.3	22.2
AS 50mg+AQ 153mg co-bl. Tab/6+6	0.4	0.7	35.8	0.4	0.6	34.4	.	.	.
AS 50mg+AQ 153mg co-bl. Tab/12+12	0.9	1.2	21.8	0.8	1.0	26.0	.	.	.
AS 50mg+MQ 250mg co-bl. Tab/3+1	.	.	.	0.9	1.1	17.7	.	.	.
AS 50mg+MQ 250mg co-bl. Tab/6+2	.	.	.	1.8	2.2	18.1	.	.	.
AS 50mg+MQ 250mg co-bl. Tab/9+3	.	.	.	2.3	2.9	18.5	.	.	.
AS 50mg+MQ 250mg co-bl. Tab/12+5	.	.	.	3.6	4.6	20.2	.	.	.
Amodiaquine 135mg+Arte50mg tab/3-PAC-25	.	.	.	.	.	.	0.4	0.4	11.6
Amodiaquine 67.5mg+Arte25mg tab/3-PAC-25	.	.	.	.	.	.	0.3	0.3	0.0

(*) WAP: weighted average price in USD; adjusts prices based on the quantity purchased.
(+) Δ: percentage difference between the budget and WAP prices.
Source documents:
WAP: 3rd Annual Report p.8
budget price year 1: 1st Annual Report, page 9.
budget price year 2: 2nd Annual Report, page 8.
budget price year 3: 3rd Annual Report, annex 5.

Based on the results at mid-term, to what extent are the objectives likely to be achieved?

According to UNICEF Procurement Division, the project has delivered 28.5 million treatments in 36 months (December 2007 – December 2010). Assuming a linear level of activity, this represents about 790,000 treatments per month. To achieve the target of 43 million by the end of 2011, the project would have to deliver an additional 15 million treatments in 12 months (see Table 3~~Table 3~~,).

This would represent about 1,250,000 treatments a month, which is higher than the average level of activity for the previous three years. Nevertheless, if one considers the level of activity for the last year, where more than 15 million treatments were delivered, one sees that this represents an average of 1.25 million treatments per month. Therefore, between year 1 and year 3, the number of deliveries accelerated dramatically. This suggests that achieving the final target by the end of 2011 is feasible if UNITAID maintains a similar pace.

Exhibit 4 mentions several other objectives. Since there were no targets established for these objectives beforehand, it is not feasible to estimate the likelihood that they will be met. The exhibit specifies that most of the targets are either not applicable, i.e. that no measurement is required, or may need to be agreed upon with Partners during UNITAID Working Group meeting.

What are the main factors influencing the achievement or non-achievement of the objectives?

Selecting the GFATM as the implementing partner for this project seemed reasonable, considering its essential role in the funding of national malaria control programs, as well as the es-

tablished systems that collect information on patients treated in the countries. However, channelling UNITAID's contribution through the GFATM grant management system was also a factor in slowing down the achievement of UNITAID objectives, due to:

- Initial selection of grants that had a defined lifespan (2 or 3 years). The reallocation of funding to other grants was complex
- Complex procedures for procurement and supply management (subject to approval of PRs procurement and supply management plan, annual budgets, etc.)
- GF disbursements to grant are based on performance. While all selected grants performed well, some could be downgraded during program implementation.
- Additional complexity of national programs; having to separately forecast ACT procured with GFATM funding and ACT received directly from UNICEF

At the time the proposal for this project was developed (2006-2007), a shortage of funds for ACT might have been anticipated. However, the development of amounts pledged to the GFATM[8] show that this was not the case, as 9,624,219,775 USD were pledged between 2001 and 2007, and around 3 billion USD per year were pledged from 2008 to 2011. Due to the decrease of funding for the GFATM over the last 2 years it is possible that the use of UNITAID funds might increase during the upcoming year.

During the period, the GFATM/PMI contribution for ACT increased and the World Bank launched the Booster program, therefore ensuring additional country funding for ACT. With the exception of Cambodia, Indonesia and North Sudan, all the others grants are implemented in Presidential Malaria Initiative focus countries. Considering that the supply from donors other than UNITAID will either remain stable or increase in upcoming years, it is unlikely that demand for UNITAID funded ACT will increase. Rather, it will remain constant or decrease.

5.3 Efficiency

This section reports on the assessment of whether partners are using UNITAID funding in the most efficient manner in order to achieve the objectives of the project. This covers aspects around the procurement model, the coordination with national authorities, as well as other aspects of implementation arrangements depending on the project.

Rating		**Quality of supporting information**	
☐	Good performance	☐	Good
☒	Some concerns	☒	Moderate
☐	Major concerns	☐	Poor

Key findings:

- Budget execution rate was 71% and budget absorption rate was 56%.
- There were no MoU with the beneficiary countries. However, the agreements were formalized as Implementation Letters to the existing grant agreements signed between the GFATM and the Principal Recipients.
- Implementation Letters were not systematically signed to reflect the latest UNITAID contribution and revision of treatment targets.
- UNICEF implements standard procurement strategies that seem to be functioning well and able to respond to procurement problems.

[8] Pledges and Contribution file accessed at http://www.theglobalfund.org/en/about/donors/public/

Are disbursements according to the budget?

The budget execution and absorption rates (see table below) were estimated from years 1 to 3. Most of the budget was disbursed in the first period (for the next 18 Months). Overall, 71% of the budget for the period was disbursed to UNICEF.
Budget absorption rates show delays in the actual spending of the budget by UNICEF, due to postponements in the implementation of the project. Overall, 56% of the budget for the period was actually disbursed by UNICEF to procure ACT treatments.
As suggested by this table, a significant amount of funds were held at the UNICEF level throughout the duration of the project. Disbursements were not linked to the actual use of funds (or forecasted use of funds) at the UNICEF level.

Table 7. Budget, disbursements and budget indicators by period

Period	Budget USD[1]	Disbursement made USD[2]	Expenditure[3]	Budget execution	Budget absorption
November 2007 to June 2008	3,705,195	15,601,173	2,716,575	421%	17%
July 2008 to June 2009	14,093,516	13,773,381	9,584,215	98%	70%
July 2009 to June 2010	21,336,351	7,083,305	8,202,648	33%	116%
July 2009 to December 2010	12,524,752 (estimated)	-	-	-	-
Totals	**51,656,815**	**36,457,879**	**20,503,437**	**71%**	**56%**

Source documents:
[1] 4th Interim report, Annex 5, Revised budget 26 July 2010.
[2] 4th Interim report, page 20.
[3] 3rd Interim Report (revised version), Annex 9, Financial report summary. Inconsistencies found reported under section 5.6 Comments on reporting~~Comments on reporting~~).

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Are the project partners working closely with the relevant national authorities in the projects' beneficiary countries? (where applicable to the project)

The MoU for this project was signed between UNITAID, UNICEF and the GFATM on the 4th December 2007 to establish the terms of the collaboration for the "ACT Scale up Initiative".

According to the 1st Annual Report, in January 2008 letters signed by all three partners were sent out to selected participating countries containing information about the initiative's goal to increase ACT delivery capacity of ongoing GFATM grants
No MoU was signed with the beneficiary countries, it was the GFATM responsibility to select and inform the beneficiary countries of the new UNITAID funding for ACT treatments. Information about the increased treatment targets was communicated to each GFATM grant, after GFATM, PRs, and CCMs. This was done through Implementation Letters that amended the GFATM grant agreements according to GFATM internal procedures (i.e. Implementation Letters are used as a record of agreements with the Principal recipient on any amendments to the initial grant agreements, such as revised targets or change in budget).

However it appears that UNITAID contribution and subsequent revision of targets were not systematically formalized. For example, IL for Ethiopia and South Sudan were never signed. UNITAID has found it difficult to follow up on grants management by the GFATM. This may be because the GFATM contact person for the 'ACT Scale-up' project belongs to the Resource Mobilization team and is therefore not well acquainted with the management of UNITAID recipient grants, which falls under the Country Programs' direction.

Is the project's procurement model well defined and designed to identify and solve procurement-related problems as they arise?

UNICEF was the procurement agent selected to design and implement the procurement strategy for the project. UNICEF was chosen because it operates with proven and established procurement procedures under stringent quality assurance processes. Additionally, UNICEF is well integrated with WHO procurement procedures. The procurement strategy put in place by UNICEF was only described in section 5.3 of the MoU and according to UNITAID (as requested by emails the 29 and 30 March 2011) there were no other specific documents addressing the procurement strategy. ,

In exceptional circumstances and subject to mutual agreements of the parties, UNICEF issued tenders to meet specific project needs not covered in the UNICEF/WHO tender (e.g. such as specific packaging/labelling for Cambodia and Madagascar). UNICEF procedures are therefore generic and seem able to address most of the procurement-related problems.

UNITAID judged the implementation of the procurement strategy as successful. The average lead time between the purchase order and the reception of the products in the countries was significantly reduced, no stock-outs took place and no country emergency requests were reported.

5.4 Impact

This section reports on the assessment of to what extent it is possible to demonstrate the impact of UNITAID funding in the target countries.

Rating		Quality of supporting information	
☐	Good performance	☐	Good
☐	Some concerns	☐	Moderate
☒	Major concerns	☒	Poor

Key findings:

- No data was available to ascertain the UNITAID specific contribution in terms of impact.

Can the partner organization attribute UNITAID funding to medicines and diagnostics purchased and patients treated by beneficiary country in a timely manner?

The number of treatments delivered by UNICEF is based on the order status table issued by UNICEF per country in coordination with the approval from the GFATM grant manager in charge of the ACT forecast demands. Furthermore, the project does not report information on ACT received by patients according to the funding source. This reporting constraint was duly recognized in the signed MoU. To address the progress towards new treatment targets, the 1st annual report noted that "*as per the MoU, ACT treatments (GFATM and UNITAID) are tracked and monitored under one combined indicator with one combined treatment targets*". Therefore, it was not possible to ascertain how many patients treated in target countries were benefiting from UNITAID funded ACT.
Given that UNICEF and GFATM collaborated on the implementation of this project, it can be questioned if they should have reported the number of treatments delivered in country / and an estimate of the number of patients treated with those ACT in each country (as the other funding sources for ACT were known by the GFATM).

5.5 Project Specific

Demonstrate that this project is being implemented in the most efficient way compared to alternatives

UNICEF tender processes and selection of suppliers and manufacturers suggest that competitive pricing was achieved without exceptions.

28,322,540 treatments have been delivered and 20,503,437USD has been spent since the start of the project. This corresponds to roughly 0.72 USD per treatment, which represents good value for money. For example, the MSH drug price guide indicates that the median price for Arthemeter-lumefrantine (20mg+120mg, 12 tab) was 0.99 USD in 2007, 0.79 USD in 2008, 0.84 USD in 2009 and 0.81 USD in 2010. At the same time, the annual average amount paid

by the project is 0.74 USD in 2008 and 2009, and 0.72 USD in 2010. This demonstrates good procurement efficiency from the procurement agent.

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The Affordable Medicine Facility Malaria (AMFm) initiative could be an alternative mechanism to increase ACT use by encouraging the private sector use of ACT. While ACT are free of charge in public health clinics, more than 60 percent of malaria patients in sub-Saharan Africa buy their antimalarial treatment from the private sector. Thanks to the Affordable Medicines Facility – malaria (AMFm) in Kenya, for example, some outlets are selling ACT for the equivalent of about 0.02 USD, more than ten times less than the pre-AMFm average price. This could be attributed to promising preliminary data that suggests that subsidized ACT rapidly displace old, no longer approved anti-malarial drugs.

Another initiative led by NetGuarantee, a subsidiary of the non-profit organization 'Malaria No More', works with a broad range of partners, including the GFATM, by offering a form of payment guarantee to expedite the delivery of life-saving mosquito nets. NetGuarantee enables suppliers to manufacture life-saving mosquito nets before countries receive grant funding from multilaterals. This process significantly reduces the time between grant disbursement and the delivery of mosquito nets to the recipient country, thereby protecting millions of people in at-risk communities more rapidly than ever before. UNITAID might consider applying a similar approach to increase access to ACT and to lower the price.

Can price reductions (as opposed to cost savings) be demonstrated by this project?

Continuous supply of high quality ACT at the apparently lowest possible price was reported and achieved by the UNICEF tendering process for this project. These reductions may also be influenced by other factors outside of the UNITAID project (e.g. the marginal reported price decrease might be because major manufacturers compete for the same target price). There is no evidence that the increased number of ACT manufacturers has significantly influenced the average weighted price. UNICEF confirmed that many variables are at stake and that the proportion of UNITAID-funded ACT currently represents a limited percentage of the total ACT procured worldwide (9.3% of the GFATM, PMI, WB Booster program for the period 2005-2010).

Have effective steps towards transitioning this project to more sustainable sources of funding been taken?

No evidence on plans to ensure the transition of this project was found. The renewal of GFATM grants for ACT deliveries for each individual beneficiary country is always possible, but this provides less flexibility because the GFATM grants do not support scale-up. Evaluators are uncertain whether the current UNITAID participation in the AMFm initiative for subsidized ACT in the private sector can be seen as a continuation of the ACT scale-up program or if it represents a new approach to increase ACT use. However, considering that the result for the AMFm pilot phase will be available soon, the evaluators estimate that UNITAID might consider increasing funding to AMFm and terminating the ACT Scale up project.

5.6 Comments on reporting arrangements

Rating		Level of confidence	
☐	Optimal	☐	Optimal
☐	Minor concerns	☒	Minor concerns
☒	Major concerns	☐	Major concerns

Key findings

- A reporting process was put in place, ensuring the timely submission of all interim and annual reports
- No formal process was put in place to clarify project related issues.
- No standardized reporting template has been developed so far.
- UNICEF and GFATM reported that UNITAID requests for reporting were increasingly complex and time-consuming
- The reports were not always well standardized, and the content of the reports (interim and annual) was not well structured, with key information hard to find.
- Names of documents were not always consistent and meaningful, considering their contents

As agreed in the MoU, a clear reporting process was put in place by the project team for interim and annual reports. Reports were submitted on time and accepted, except for the interim report of June 2010. No formal process was set up to clarify project related issues, such as revised targets, alliance management, partner expectations on requests, turnover time for decisions or revisions of the scope of the work.

According to UNITAID, some documents that allowed verification of implemented activities were not available:

- All agreements signed by the GFATM with beneficiary programs;
- Documents addressing the procurement strategy, other than the generic description in the MoU;
- The buffer stock arrangement;
- For 3 out of 12 planned activities, it was not possible to confirm their implementation

There was no specific or standardized reporting template used throughout the lifetime of the project that would have allowed a direct link between programmatic and financial information and including a summary version. Nevertheless, a template was under review at the time of the mid-term review, which included more specific reporting requests that seemed to create an additional burden to partners. For example, during the meeting with the GFATM, it was mentioned that reporting was very time-consuming, and the GFATM was reluctant to provide more information than what has been provided for the former reports. UNICEF mentioned that it was at times unclear why certain information was needed.

At the UNITAID level, the evaluation team noticed some archiving issues, since documents received from implementing partners by UNITAID were not well organized. There was no naming convention for documents, making it difficult to retrieve information. For example, the document called “financial report” in the 3rd annual report (i.e. annex 9) and in the 1st annual report (i.e. annex 10) was actually two

different documents: in the first case it was a cash reconciliation and in the second it was a summary of the transaction for the different countries.

Finance reporting requirements and contractual supporting documentation requested by UNITAID were not fully detailed in the project plan or in the MoU of projects. The financial reports were not always standardized and some information was difficult to find. Several inconsistencies were noted in the reports, either within the same reports (e.g. between the report and its annexes) or between the reports for different years. For example, in the 3rd annual report (revised version), the information in Annex 8 (which is actually a synthesis of the drugs funded by UNITAID from year 1 to 3) and in Annex 9 (called "cash reconciliation as per last approved budget July 2010") was inconsistent: for year 1, the expenditure amount was 2,716,575.46USD and 2,588,928.4 USD respectively; and for year 2, it was 9,584,214.7USD and 9,456,568 USD.

Budget adjustments and reallocations are not systematically formalized in an addendum to the initial MoU officially approved by both parties. Considering the number of possible financial revisions that can occur throughout the duration of the projects, this is a source of confusion and a limitation to efficient financial management.

5.7 Projects Strengths, Weaknesses, Opportunities and Threats (SWOT)

The following table suggests some items that could be considered if the project plans to engage in a SWOT analysis. This analysis must be carried out over a certain period of time, ensuring the participation of key stakeholders. From the above findings, these issues might be worthwhile to consider.

Table 8. Suggested items for a SWOT analysis.

Strengths	Weaknesses
• Targets could realistically be achieved • Sufficient funding • Experienced partners • Channelling the funds through GFATM ensures that funding is going to well-performing programs	• Channelling funds through GFATM grant management system slows down execution • Relative slow capacity to identify and react to slow implementation • Impossible to establish UNITAID specific contributions. • No risk assessment plan
Opportunities	**Threats**
• Reduce Malaria burden in 8 countries • Support several Millennium Development Goals • UNITAID as a key player in fighting Malaria • To apply lessons learned	• External factors on ACT demand, use, other source of funding and pricing • Dependence on country ACT demand /forecast and capacity to absorb ACT

Strengths

- Considering the number of treatments delivered so far and the pace of activities related to ACT delivery, treatment targets should be achieved with limited additional efforts.
- There was not budget bottleneck
- Dedicated partners who work in their area of competence (UNICEF, GFATM)
- Global Fund performance-based funding principle ensures that funding is going to well-performing grants

Weaknesses

- Since funds are channelled through the GFATM grants management system, which respects the performance-based funding principles and is related to the grant cycles, some delay in program execution can be implied.
- The capacity to identify and react quickly may be limited in case of an unsatisfactory implementation. Reallocating UNITAID funding to other GFATM grants in case of poor performance, or at the end of a beneficiary grant is complex and time-consuming.
- It is not possible to measure how UNITAID's contribution affected the number of patients treated with ACT
- No risk assessment plan was in place for ACT Scale-up

Opportunities

- UNITAID contributes to the fight against malaria in the target countries, and thus helps these countries be on track to reach MDG 4 and 6.
- By providing key supports to developing countries, UNITAID has a major role reducing the malaria burden.
- This project is an opportunity to learn from inconsistencies / difficulties that occurred during its lifetime.

Threats

- ACT demand and usage can be affected by external factors, to which UNITAID cannot always react.
- ACT price is also influenced by external factors
- The usage or absorption capacity for ACT from the beneficiary countries can be too low and thus UNITAID support may not be utilized.

6 Conclusions and Recommendations

	Conclusion	Recommendation	Responsibility
Project management and implementation			
1.	The project can realistically achieve the final target by the end of 2011	UNITAID should continue funding the project until the end of 2011 and make sure that implementing partners report on final achievements of the project in a timely manner.	UNITAID with GFATM
2.	The complexity of implementation arrangements hindered the efficiency of the project.	In the future, UNITAID should consider channelling its funds through more efficient implementation arrangements. One option is to increase its contribution to AMFm, once more evidence on AMFm impact is available.	UNITAID
3.	Since the project was implemented through Global Fund grants, it was difficult for UNITAID to follow-up on specific grant implementation and to keep track of changes in grants for different countries.	UNITAID (portfolio managers) should monitor key changes in beneficiary countries that are likely to have an impact on the project. A section for key country information should be included in the report template.	UNITAID and the GFATM
4.	No risk-assessment for the project exists	Design and implement a risk management plan addressing phasing-out, reporting, control, budget and target objective changes and project management. An external consultant expert in the topic could be contacted.	UNITAID with input from UNICEF and GFATM
5.	There was a significant amount of funds held by UNICEF throughout the project as a result of delays in the spending of funds received from UNITAID	UNITAID should in its MoU require its partners to report on interests earned (to be reallocated to the project or deducted from the next disbursement). Disbursements should be more closely linked to performance	UNITAID with input from UNICEF and GFATM
Monitoring and Evaluation			
6.	It is not possible to estimate specific UNITAID contributions in terms of number of patients treated with ACT	As lessons learned for future projects, UNITAID should make sure that key indicators of performance defined for its projects are measurable. UNITAID could plan for consumption surveys in sentinel sites or it could redefine indicators that measure only the number of treatments procured.	UNITAID

	Conclusion	Recommendation	Responsibility
7.	In Exhibit 4, indicators are not sufficiently well defined and targets are not set. There is no clear link between activities, objectives and indicators. Some activities are more related to project management activities. Some indicators are not directly measurable.	Establish a common logframe template for all projects, with a menu of suggested objectives. This template could be used to assist formative evaluation in the course of the projects. The indicators should be more precisely defined and the targets should be specified.	UNITAID with input from UNICEF and GFATM
8.	In Exhibit 4, it is planned to measure ACT price reduction by the weighted average price.	Market price reduction should be measured using market price reduction over time. In addition, the comparison of WAP paid by the project to the market price should be used to measure procurement efficiency	UNITAID with input from UNICEF and GFATM
Reporting			
9.	The archiving systems at UNITAID Project Management do not seem able to cope with the variety and complexity of information handled	UNITAID should set up an internal document filing system common to all projects, consistent with standard archiving and knowledge management procedures. The website could be empowered, if is not yet, with a Content Management System (CMS)	UNITAID
10.	Inconsistencies in the information reported were noted in the progress reports and annexes.	Simplify the reporting requirements; select a few programmatic and financial indicators, integrating them into existing data reporting systems. Establish systematic data quality checks.	UNITAID with input from UNICEF and GFATM
11.	The project plan did not provide any reporting template for either the interim or the annual report. This meant that the reports were not always well standardized. The contents of the reports were not well structured and key information may not be available.	A clear template for interim and annual reports, including a programmatic and financial section, should be provided. Such templates should include tables / figures and annexes, as expected by UNITAID	UNITAID

Annex 1. Evaluation matrix

Table 9. Evaluation matrix of the common evaluation areas.

Evaluation area and question	Indicators	Sources	Methods
Relevance			
1- Are the activities and expected outputs of the project consistent with the objectives and expected outcomes as described in the project plan?			
1.1 Are the activities from the project plan consistent with the objectives?	Consistency Rates - Number objectives with activities / total (%) - Number activities related to objectives / total (%)	- In the project outline, match the activities with the objectives	Match activities planned to reach each objective Also indicate if some of the activities are not linked to any of the objectives, and question their relevance
1.2 Do indicators as defined in the project plan allow to measure progress on each of the objectives?	% of objectives measured with at least with one relevant indicator	- In the project outline, match the objectives with the indicators	Comment on the development of a logframe for the project
1.3 Are all activities implemented as scheduled for the period?	Activity completion rate - Number activities implemented / total	- Planned activities from project plan - Implemented activities from the last available progress report	Follow up on the completion of activities and milestones as described in the project plan. Give reasons for delays.
1.4. Are disbursements according to current budget forecasts and expenditures on the progress report?	Budget execution rate % (Disbursements vs. Budget) Budget absorption rate % (Expenditures vs. Budget)	- Budget from project plan - Disbursements and expenditures from financial reports	- Calculate total expenditures / Disbursements for the period / Budget - Verify that expenditures are in line with activities initially planned / implemented - Explain main variances
2- Is it possible to show how the project contributed to UNITAID's overall goal of using innovative, global market-based approaches to improve public health by increasing access to quality products to treat, diagnose and prevent HIV/AIDS, tuberculosis and malaria			
2.1 Has the project already demonstrated the contribution of UNITAID to increased access to quality products to treat/diagnose HIV, TB, and Malaria?	Yes / No	- Progress reports - Estimated number of patients treated or diagnosed per country	
2.2 Are the numbers reported by the implementing partner reliable?	Yes / Mostly / No	- Description of methods to estimate patients treated (if available) - Interview UNITAID / partner	How did the partner estimate the number of expected patients treated (or diagnosed)? Are the methods reliable? Does the partner have programmatic support in countries - ensuring that treatments procured are effectively dispensed? Can the numbers be cross-checked with the number of treatments procured?

Evaluation area and question	Indicators	Sources	Methods
Effectiveness			
3- To what extent were the objectives of the project achieved?			
3.1 Were the targets of the project achieved in terms of Health Outcome (estimated number of patients treated or diagnosed)	% achievement rates on patient outcome indicators.	- Project outline - targets in terms of health outcomes - Results from the most recent progress report	- Comment on the achievements in terms of patient outcome (Number patients treated / diagnosed) against the targets - Comment on reliability of information
3.2 Were the targets of the project achieved in terms of Market outcome?	Include quantitative result / % achievement rate (or qualitative if % not applicable)	- Project outline - targets in terms of market outcome - Results from the most recent progress report - Verify with market information (WHO pre-qualified product/supplier list, MSH drug price indicators)	Comment on the achievements in terms of market outcome (price, quality, availability, access)
4- To what extent are they likely to be achieved?			
4.1 Likelihood of achieving health outcomes objectives	High / Medium / Low	Progress reports / interviews	No data collection here - This should be answered in the evaluation based on what has been achieved and what is known on the project
4.2 Likelihood of achieving market objectives	High / Medium / Low	Interviews / Market knowledge	No data collection here - This should be answered in the evaluation based on what has been achieved and what is known on the market for the drug or diagnosis
5- What are the main factors influencing the achievement or non-achievement of the objectives?			
5.1. What were the reasons for not meeting patient outcome targets?	List of factors.	Progress reports / interviews	For the main patient outcome indicator, analyze the chain of events: - were the activities from the project plan implemented? - if yes, what were the factors for not achieving the targets - separate internal factors (related to partner's organization and project implementation) and external factors (country context, market, complementary funding,)
5.2. What were the reasons for not meeting market impact targets?	List of factors.	Progress reports / interviews	- were the activities from project plan implemented? - if yes, what were the factors for non achievement of targets
5.3. Was there an effective risk management plan in place during the project?	Yes / Limited / No	Progress reports / interviews	1- Did the partner make an initial risk assessment? 2- Were the issues that happened during implementation foreseen in the risk assessment? 3- Did the partner take mitigation measures to limit the impact of negative events?
Efficiency			
6- Are the project partners working closely with the relevant national authorities?			
6.1 Has MoU been signed with all beneficiary countries?	Number of MoU Signed / Total planned	- Latest progress report - Update by interviews	- Number of MoU signed against number planned - Analyze the reasons for MoU not having been signed
7- Is the project's procurement model well defined and designed to identify and solve procurement-related problems as they arise?			
7.1 Is a procurement agent selected and operational for the project?	- Yes (Name) - In progress - Process not started	- Progress Update - Latest procurement review	

Evaluation area and question	Indicators	Sources	Methods
7.2 Is the product median price procured in line with the budget?	Median unit cost / Planned unit cost (%) for key selected products	- Procurement orders - Targets and budget from initial project plan	- Select a few items driving the overall procurement budget - Comment on the reliability of information
7.3 What is the average lead time between purchase order and reception of health products in country?	average lead time for all operational countries	- Project plan - Progress reports - Copy of order sent by the country, reception certificate	Target time - effective time (in months) Number of months Delay / Lead compared to project plan Calculate average lead time for all the countries (in case there are minority of extremes values, do not include them but mention in the comment) Is it in line with the initial plan?
7.4 How many stock-outs of more than 7 days were observed since the beginning of the project?	Number of stock-outs	- Progress reports if information is reported - Otherwise ask the implementing partner	Identify likely reasons for stock-outs, attribute stock-outs to reasons - Number of stock-outs with responsibility - Number of stock-outs without responsibility
7.5 Is the procurement model functioning as designed in the project plan?	- Yes - No	- Compare procurement model from project plan to reality	If deviations from the project plan are identified, try to obtain information on the reason for change.
Impact			
8- Can the partner organization attribute UNITAID funding to medicines and diagnostics purchased and patients treated by beneficiary country in a timely manner?			
8.1 Did the project report on treatments/diagnostics procured per country under UNITAID Funding?	No. of treatments/diagnostics procured per country	- Latest progress report	
8.2 Did the project report on patients treated/diagnosed per country under UNITAID scheme?	No. of patients treated/diagnosed with UNITAID funding per country	- Latest progress report	

Table 10. Project specific questions.

UNICEF - ACT Scale up
1-Demonstrate that this project is being implemented in the most efficient way compared to alternatives
1.1- Ratio of the project amount by number of people treated
1.2. Comparison to other benchmarks available
1.3. Since the program has started, how many patients have been treated with the ACT scale up program?
2-Can price reductions (as opposed to cost savings) be demonstrated by this project?
2.1 What is the average number of patients benefiting from the ACT scale up?
2.2 Is the method used to estimate patient numbers appears to be accurate?
2.1. Decrease of median price of ACT included in the AMFm after project starting date
3-Have effective steps towards transitioning this project to more sustainable sources of funding been taken?
4.1 What is the list of actions taken?
4.2- What results have been obtained so far?

Table 11. Reporting checklist.

Reporting received from implementing partners
1.1 Are project reports (interim report, annual reports) submitted on time?
1.2 Are they many clarifications required by UNITAID following the transmission of reports?
1.3- Is the content of the reports organized according to the requirements in the project plan?
1.4 Is the content of the report useful for decision making?
1.5 What is the internal UNITAID process for validating a progress report? How could it be improved?
Financial reporting
2.1 Are the reporting requirements clear in the project plan and MoU?
2.2 Does the financial reporting format allow identifying readily common budget items (e.g. salaries, travel, major acquisitions, and drugs/diagnostics)?
2.3 Does the financial report give a clear picture on activities implemented and expenditures spent in the period compared to the budget and work plan?
2.4 Does the project implementation follow performance based funding principles? Are the disbursements based on progress made?
2.5 Are interests received on bank accounts or others' incomes reported and are they reimbursed to the program / deduced on disbursement requests?
2.6 Does the financial reporting include a cash reconciliation supported by financial statements and bank statements?
Programmatic reporting
3.1 Are indicators defined both at the process level and at the outcome/impact level?
3.2 Does the programmatic / procurement report follow UNITAID requirements in terms of content?
3.3 Does the programmatic report provide a clear and actionable picture of programme implementation?
3.4 Does the programmatic report provide a clear picture on procurement activities (order list, etc…)?

Annex 2: Meetings with Stakeholders, Questions and List of Persons Interviewed

The Interview with UNITAID and GFATM covered the following topics:

1. Lessons learned (if any) regarding deliverables for the ACT scale up.
2. Role of UNITAID regarding the progress monitoring of the project.
3. Document supporting GFATM rating changes of participating countries. Ghana, Cambodia, Madagascar, North Sudan, Indonesia, Ethiopia were all down graded from initial start (2006) to 2010. Why? What was its impact on the overall deliverables for the ACT programs?
4. Was there any communications back to UNITAID about these issues?
5. Was a pre-agreed template put in place regarding intermediary reports?
6. How would you characterize the partnership with UNICEF on the ACT scale up?
7. How would you characterize the partnership between GFATM/UNICEF and UNITAID?
8. What would you do differently in the future? Alternative models for collaborations?
9. Why were only pdf reports made available to UNITAID at the beginning, and not the original xls/raw data?
10. What is the mechanism used to choose a GFATM project manager for a program like this?
11. There were at least four project coordinator changes within 6 months, any particular reason?
12. Was a risk management plan in place?

The interview with UNICEF covered the following topics:

1. Lessons learned (if any) regarding deliverables for the ACT Scale-up.
2. Role of UNITAID regarding the progress monitoring of the project.
3. Was a pre-agreed template put in place regarding intermediary reports? (change of styles, content)
4. How would you characterize the partnership with GFATM on the ACT scale up?
5. How would you characterize the partnership between GFATM/UNICEF and UNITAID?
6. What would you do differently in the future? Alternative models for collaborations?
7. What is the mechanism used to choose a UNICEF project manager for a program like this?
8. Was a risk management plan in place?
9. "Learning and training of health workers, education": please comment or give supporting documents on scope, and funding origin.
10. Reports or copies of the Customer Satisfactory Survey especially Ethiopia, South Sudan
11. Procurement strategy: please comment or give supportive documents on UNICEF procurement roles, was UNITAID involved?
12. Pricing: what are the variable(s) around ACT pricing?

Table 12. People interviewed.

Stakeholder	Name of person interviewed	Title	Role in the project
UNITAID	Imelda de Leon Kate Strong	Portfolio Manager M&E Manager	Project Manager, report editing to UNITAID board M&E
GFATM	Humberto Laudares	Innovative Financing Officer	Focal point GFATM
UNICEF	Francisco J. Blanco Tina Mortensen	Chief, Medicines and Nutrition Centre	Focal point UNICEF – in charge of procurement

Annex 3: List of Documents Reviewed

Source	Document Title	Year
Board Resolutions	Resolution n°6	10 Oct 2006
Board Resolutions	Resolution n°12	29-30 Nov. 2006
Board Resolutions	Resolution n°5	05 Feb 2007
Original MoU with Updated budget	MoU	Nov. 2007
First Amendment to the MoU	Amendment to the MoU	20 July 2009
1st Interim Report	- 1st Interim Report - Annex 1, Treatment targets - List of indicators on achievement of objectives under the project - Original exhibit 1 to MoU	March 2008
1st Annual Report	- 1st Annual Report - Dec 07 to Jun 08 - Annex 1-4 annual programmatic report Sept 2008 - Annex 5 (Various documents from countries to GFATM) - Annex 6 Updated budget - Annex 7 Disbursement schedule as per updated budget - Annex 8 UNICEF order status table - Annex 9 Customer survey - Annex 10 Financial report	Sept 08
Final version Second Interim Report	- Final version Second Interim report July 08 to Dec 08 - Annex 1-4 (Countries & grants participating in scale up, Treatment targets, Stock-out indicators, Grant performance rating) - Annex 5, Updated budget - Annex 7, Order status report	May 2009
2nd Annual Report	- 2nd Annual Report July 2008 to June 2009 - PUDR, Sept. 2009 - Budget	Sept 2009
3rd Interim Report	- 3rd Interim Report July – Dec. 2009 - Annex 1-4 (Countries & grants participating in scale up, Treatment targets, Stock-out indicators, Grant performance rating) - Annex 5, revised budget - Annex 6, Order status report - Annex 7, Procurement pricing report 31.03.2010 - PUDR, March 2010	March 2010
3rd Annual Report	- 3rd Annual Report September 2010 (resubmitted) July 2009-June 2010 - Annex 1-4 (Countries & grants participating in scale up, Treatment targets, Stock- out indicators, Grant performance rating) - Annex 5, Order status Sept 2010 - Annex 6, Order Status table Sept. 2010 - Annex 7, Procurement pricing report - Annex 8, Projected Year 4 Budget, 31.03.2011 - Annex 8a Projected extension budget 31.03.2011 - Annex 9 Template financial reporting March 2011 - PUDR March 2011 (signed)	March 2011

Source	Document Title	Year
Report to Executive Board	Semi annual reporting on progress of approved projects, operations	Dec 2007
Report to Executive Board	Semi annual reporting on progress of approved projects, operations	Dec 2007- June 2008
Report to Executive Board	Semi annual reporting on progress of approved projects, operations	Dec 2007 – June 2009
Report to Executive Board	Brief format Act Scale Up	May 2010