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Evaluation of the Medicines Transparency Alliance Phase 1 2008-2010

Main Report

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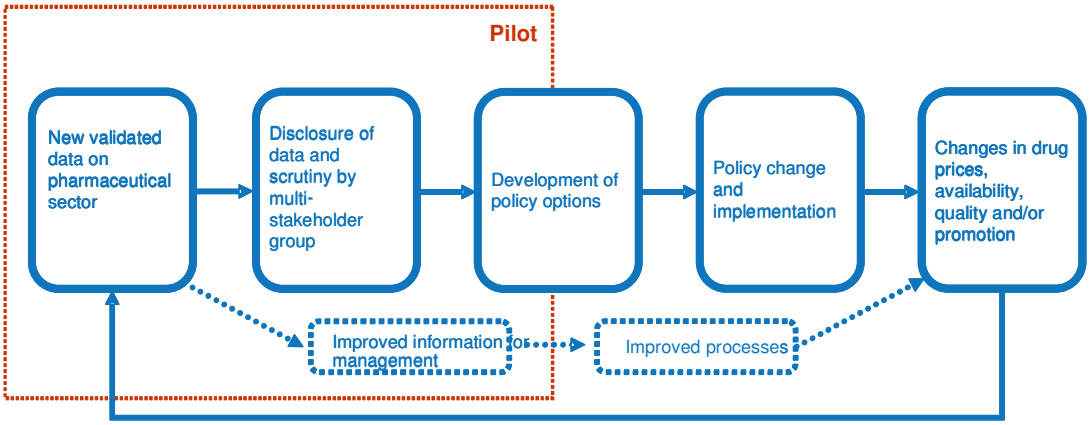
Abbreviations

AtM	Access to Medicines
CSO	Civil society Organisations
DFID	Department for International Development
DOS	Department of Statistics (Jordan)
EC	European Community
EFO	Externally Funded Output
ED	Executive Director
EITI	Extractive Industries Transparency Initiative
EMP	Essential Medicines and Pharmaceutical Policies(WHO)
FDB	Food and Drugs Board(Ghana)
GFATM	Global Fund for AIDS, TB and Malaria
GGM	Good Governance for Medicines Programme (WHO)
HAI	Health Action International
HERA	Health Research in Action
HPI	Health Partners International
IAG	International Advisory Group
IDS	Institute of Development Studies, Sussex
IFPMA	International Federation of Pharmaceutical Manufacturers Associations
M and E	Monitoring and Evaluation
MAR	Medicine, Access and Rational Use (WHO)
MeTA	Medicines Transparency alliance
MOH	Ministry of Health
MOU	Memorandum of Understanding
NGO	Non governmental organisation
NPO	National Professional Officers
PRA	Pharmaceutical Regulatory Authority (Zambia)
RAAKS	Rapid Appraisal of Agricultural Knowledge Systems
SURE	Securing Uganda's Right to Essential Medicines (USAID funded)
TA	Technical Assistant
TRIPS	Trade related aspects of Intellectual Property Rights
TTL	Task Team Leader
UNITAID	Global initiative to scale up access to treatment for HIV/AIDS, malaria and TB
USAID	United States Agency for International Development
WB	World Bank

WHA	World Health Assembly
WHO	World Health Organisation

1. Summary

MeTA is based on the following model which takes lessons from the Extractive Industries Transparency Initiative (EITI) and there was a recognition from the start that the results chain would not be wholly achieved in the pilot phase.



The evaluation of MeTA examined both progress towards achievement of the results chain but also sought whether;-

Countries can establish functioning multi-stakeholder groups to agree plans for the generation and disclosure of robust policy relevant information on the price, quality, availability and/or promotion of medicines.

MeTA can build capacity to and result in the disclosure and scrutiny of relevant and high-quality information on the price, quality, availability and/or promotion of medicines

MeTA can facilitate the development of informed proposals for changes in policy and business practices

Establishing a Framework for MeTA in pilot countries

Gaining Government Commitment (section 13)
All seven MeTA pilot countries have now established multi-stakeholder groups (Councils) and have agreed workplans which include proposals to generate and disclose information relating to price, quality, availability and promotion of medicines. This is, in itself, a major success. Not all Councils have equal involvement from all three sectors but there is regular multi-sectoral attendance. Governance frameworks vary and not all yet conform wholly with international best practice.

Whilst much time was taken initially on process issues, there is now evidence that the longer standing councils are utilising an increasing proportion of their time on substantive issues relating to access to medicines.

Establishing National MeTA Secretariats (section14)
In country secretariats vary in size, location and capacity. There is a need to identify what competences are required and to design the secretariats accordingly. Location in WHO (Philippines) or a sector partner premises may in some cases have significant advantages (e.g. Jordan) but in others (e.g. Zambia) may compromise independence.

If new countries adopt the MeTA principles and create secretariats, it is suggested that the following points be considered:

- Optimum location for working collaboratively with complementary initiatives without compromising independence
- Need for basic minimum facilities and services
- Need to ensure that secretariat staff have range of essential competences and/ or can develop these with appropriate support
- Need to agree limits of delegation and authority

Supporting National Capacity Building (section 15)
A significant proportion of the META budget is spent on capacity building activities. Support to countries has been provided through international and national Technical Assistants (TA); in general, this has worked well.

A number of regional and international courses have been held. In general, these have been well received and fulfilled a dual role in increasing skills and knowledge but also increasing trust and engagement. Participants also value lesson learning from other countries and solidarity created when comparing successes/challenges. The Harvard Flagship course, which was adapted from the International Flagship course and was based on providing participants with both knowledge and techniques to achieve reform in pharmaceutical policies and encouraging them to share experience and learn together, was particularly successful although ideally it should have been available earlier in the MeTA establishment process.

The optimum size for learning events needs forethought and it is important that delivery agencies ensure complementarity and consistency of message. The desirability for south: south learning has been articulated but lack of a common language is inhibiting.

Workplans (section 16)
Workplanning has been relatively slow and the rate of spend has thus been low. A greater use of local TA in country might have facilitated the process. There needs to be tighter performance management of activities in some countries with payments from the councils linked to the achievement of milestones and timelines.

A message was received in some countries that workplans should aim for “low hanging

fruit" Whilst the need for demonstrable quick wins is understandable, this has resulted in MeTA being an alternative funding stream for existing activities in Uganda (and possibly other countries).

Harmonisation (section 17)
MeTA is unusual for a DFID funded programme in that it has been set up across a number of countries and outside normal country planning processes. There is a real issue about whether MeTA complies with Paris Principles given that not all workplan activities appear to be reflected in MOH planning processes.

MeTA has relatively high transaction costs and, as yet, it is not possible to demonstrate that these are outweighed by unique benefits. Whilst the question was not asked of all MOHs, there is an issue as to whether greater impact could be achieved for the investment through other existing initiatives and support mechanisms. However it is recognised that none of the complementary initiatives involves the unique MeTA multi-sectoral involvement framework.

Delivering against the MeTA Objectives in countries

Progress towards Data Identification (section 18)
MeTA has both used tools from predecessor initiatives and developed new tools. In each country a significant body of information exists, some of it generated from predecessor or complementary programmes.

Progress towards Disclosure (section 19)
Countries have all completed a disclosure survey which identifies what information is publicly available. This survey has the potential to help councils identify ownership of information, priorities for disclosure and existing gaps. Some information is already in the public domain but it will be important to ensure rigorous verification/ quality assurance and to work with key stakeholders including other programmes to establish ownership and access.

Progress towards changes in policy and business practice (section 20)
It is too early to expect MeTA to have achieved major changes in policy or business practice. However, there has been legislative change in the Philippines where MeTA members were clearly contributory and also work in Peru (the Price Observatory) which was a joint initiative with government. Work on effective medicines for the Rational Drug List in Jordan and amendments to guidelines on hypertension have also been significant. Involvement of the private and civil society sectors in strategic planning for medicines in Uganda sets a useful precedent. These are useful signs that indicate the potential of MeTA.

So far, no changes have been identified in business practice. Whilst the private sector is involved in each country forum, there is a feeling in some countries that their involvement is driven by a wish to achieve particular business results (e.g. changes in tax application etc). Whilst there is no identification of disclosure which gives mutual benefit (win: win) there is a danger that all parties are not benefiting equally from discussion and the end users of medicines may not be the winners.

Progress towards Logframe Purpose Level Objectives (section 21)
The MeTA pilot has achieved the purpose level milestones in the logframe up to date and there are good indications that all milestones up to September 2010 will be achieved. There also appear to be clear indications that progress is accelerating.

The Genesis of MeTA

Building on predecessor work and working with current initiatives (section 5 and 6)
MeTA builds strongly on the Regional Collaboration for Action on Essential Drugs in Africa Programme (DFID funded) which commenced in 2002. It has used the survey tools developed in this programme and learnt lessons relating to the creation of National Professional Officers in national WHO offices to provide support. MeTA has synergy with the WHO Good Governance for Medicines programme but the level of collaboration with GGM both nationally and internationally, is variable.

Design, tender and contract (section 7)
MeTA built on the principles of preceding work including EITI. The design work incorporated much consultation and scoping but was lengthy. The selection of countries and the number of countries chosen was probably ambitious for a pilot phase. Given the range of national languages more resources were desirable for translation and interpretation. There are lessons to be learnt from the contracting process including the need to ensure completeness of the scope of work and incorporating mechanisms which ensure delivery, without increasing the risk for the contractor to such an extent that the contract is unattractive.

International Governance

Establishing the MeTA Alliance (section 8)
It is important that all Alliance members have a common vision of both the principles and implementation methodology of MeTA. Whilst country ownership is essential, it is necessary to have clarity about

- Expectations of what common activities and approaches will be undertaken
- Where there is an expectation of conformity (e.g. the multi-stakeholder approach) and what should be subject to local determination
- What resources are available to support this (from the IMS, the World Bank and WHO
- Timescales and milestones which all countries need to meet

The MeTA Alliance is currently solely funded by DFID with some funds channelled through the World Bank(WB) and WHO. WHO has valuable technical expertise, good convening presence in countries and responsibility for both predecessor programmes and current complementary initiatives. WB has synergistic expertise particularly relating to governance and finance. With both the WB and WHO there is strong central commitment to MeTA but engagement locally cannot be assured. This is unfortunate given their presence in all countries.

For a project which has transparency at its core, there does not seem to be widespread knowledge of the total allocations (including those to the WB and WHO) and the

proportion controlled by country multi-stakeholder fora is small. It is strongly suggested that, should MeTA 2 proceed, then serious consideration be given to the allocation of resources between national and international initiatives.

It is equally important to ensure greater transparency about the totality, allocation and source of resources, how these may be accessed and who makes the decisions at which levels.(MMB, International Secretariat, Country Council, Country Secretariat)

MeTA Management Board (MMB) (section 9)
The MMB does not have clear separation between the oversight body and the implementing body. The current MMB work has, by necessity, been heavily focussed on detailed monitoring of implementation activities by the secretariat which has reduced the opportunity for a more strategic focus. There is a recognition that governance arrangements need to be reviewed for MeTA 2.

International Advisory Group (IAG) (section 10)
The role of IAG has not been sufficiently clear and both the advice required and the means for transmitting it need to be reviewed. There is huge untapped potential in the membership. The current format of meetings does not appear to give value for money

International MeTA Secretariat (IMS) (section 11)
The IMS has given cause for concern, particularly in respect of leadership and the communication function, and is perceived not to have performed well. The lack of a credible and consistent communication strategy has been a major shortfall. The staff are not co-located and some are part time and there is no team wide performance management system.

However, technical input has been well received and the operations function is well regarded. The balance of staff between technical and administrative appears inappropriate for the task. Given the large proportion of the budget which is held by the Secretariat, it is important to agree clear measurable outcomes for their work and to ensure value for money. Technical support has been much appreciated in countries where it has been delivered.

The current financial reporting does not facilitate cost benefit analysis by activity. Allocation of time by the secretariat by country/ function is not reported and it is not possible to easily calculate the totality of input into a given activity or event.

Engaging with the Private Sector (section 11.5)
There has been much contact with major international manufacturers who have expressed interest in the MeTA concept. However, none had been prepared to commit at the time of the evaluation. This may be because there is still not a clear message being articulated about what they are being asked to commit to.

Engagement with Civil Society (section 11.6)
Achieving collaborative working between CSOs has been harder in some countries where there is less precedent. Workshops for CSOs have been seen as helpful but it is not clear whether adequate ongoing support has been provided by the IMS.

Communications (section 11.7 and 11.8)
The communications function of the IMS has failed to facilitate a vision with ownership from all stakeholders and to deliver a communications strategy which would result in coherent, consistent messages both internally and externally.

There is still work to undertake both internally and externally to ensure that MeTA's principles, aims and methodologies are understood. MeTA is one player amongst many in the field of medicines worldwide and its particular and precise role needs to be articulated. It is essential that all members of the Alliance and the Secretariat have a common mutual understanding and agree key messages and are consistent in their use.

Technical Assistance (section 12)
TA has been used effectively both nationally and internationally although lines of communication and accountability have not all been clear. It will be important to retain institutional memory in MeTA 2.

Partner support WHO (section 12)
The support given to MeTA from WHO HQ has been valuable. Input at country level has been variable and the level of resources available through WHO is not transparent. The support of multilateral-funded staff/ consultants in Uganda, Jordan and the Philippines has been particularly helpful. Survey work commissioned through WHO has suffered some delays.

Partner support World Bank (WB)
Whilst the level of commitment from the WB to MMB and IAG has been considerable, it would appear that the financial investment has resulted in a response which varies significantly across countries and has not been substantial.

Are the MeTA Hypotheses Proven? (section 21)

There has been a recognition from the start that it was unlikely that the hypotheses underpinning MeTA could be proven in a short pilot period. The model appears to hold good in that MeTA councils can demonstrate that multi sector engagement is building both greater mutual understanding and a degree of trust amongst the individuals concerned. There are good indications and some hard evidence that this trust is leading to greater transparency and a willingness to identify and collect relevant information and there are plans to disclose this information, although the exact methodologies may not be finalised in all countries.

It is not yet possible to attribute major policy or business practice change to MeTA although there is progress in Philippines, Jordan and Peru.

Only in one area is there still a need for more evidence as to whether the model has validity and this is in the involvement of the private sector. Whilst there are indications of the potential of their involvement in the multi-stakeholder process, actual outputs are lacking.

The problems in the performance of the IMS need to be separated from the general adoption of the principles and achievement in countries. There is evidence that countries

are perceiving the benefits and potential benefits of MeTA and this may increase with more information becoming available shortly and some workplan activities coming to fruition.

The difficulties in establishing the infrastructure and agreeing the workplans has undoubtedly taken up much national time and effort and it appears that this could have been abbreviated with increased support from the IMS and TA. The problems, where they exist, do not appear to be so much to do with the principles than with the implementation.

In all, a great deal has been achieved both nationally and internationally in a short period of time and there appear to be clear indications that progress is accelerating.

2. Methodology

The evaluation of the MeTA initiative took place between 1st December 2009 and 28th Feb 2010. The evaluation team are aware that the MeTA initiative is dynamic and that iterative change is constant but this report does not include events or changes after 28th February 2010.

Evaluation team members were selected with the following competences:

- Skills in document review, evaluation and analysis, critical interviewing, report writing
- Knowledge of governance, management, health economics. private sector and civil society
- Background knowledge of country context in Ghana, Uganda, Zambia
- Knowledge of DFID evaluation processes
- None of the team members had worked with MeTA previously.

A framework evaluation methodology was devised by the team leader together with a standardised report format and a core of people to be interviewed (by title/ function). This was agreed with DFID in advance.

Team members visited five countries, Ghana, Jordan, Philippines, Uganda and Zambia. The Philippines visit was scheduled to coincide with the national Forum. The Uganda visit coincided with a council meeting. In addition, telephone interviews were undertaken in respect of evaluations of the work in Peru and Kyrgyzstan. Considerable background literature was made available which also informed the process. Every effort was made to triangulate information to achieve accuracy. All country reports were shared with the country Chairs and coordinators who verified factual content.

In addition to country level interviews and documentation, the team leader also attended a number of international events and conducted face-to-face and telephone interviews (see Annex 1).

The final report drew on

- The team leaders interviews, observations and document review
- Country reports
- Additional country level material supplied by the international consultants

All international consultants had the opportunity to read and comment on the main report and it was additionally subject to the HDRC's quality assurance procedures.

3. Background

MeTA was created in recognition of the key importance of access to medicines. Access is determined by complex interactions between the organisation of the supply side of the market and demand-side needs and preferences, financial capabilities and funding mechanisms. This interaction takes place in the context of a country's regulatory framework, governance capacity, and level of institutional maturity. These factors all come together to determine the prices that individuals have to pay for medicines at the time of purchase, and the range and quality of drugs available.

A key element in these interactions is the availability of good information for suppliers and consumers of medicines, as well as the regulators, to make the best decisions and to ensure accountability. Whilst many funders were working to strengthen systems for medicine procurement, distribution, prescription and dispensing, there was perceived to be a gap in moving towards transparency and disclosure of information to improve the operation of the market.

The Good Governance for Medicines Programme(GGM) and the DFID funded Regional Collaboration for Action on Essential Drugs in Africa predecessor programme delivered by HAI and WHO, were already working towards reducing corruption and increasing availability of information respectively but the MeTA concept differed in that it brought together public, private and CSO sectors. This was in recognition that all three had a role to play and it was underpinned with a belief that multi stakeholder engagement would facilitate trust and dialogue leading to sharing of information and public disclosure. MeTA was designed to tackle inefficiencies in public pharmaceutical markets and taking a "total market" approach was seen as a key principle.

There were a number of key events and predecessor initiatives which were influential on the political context and motivation behind MeTA.

The DFID paper "Making Markets Work Better for the Poor (M4P)" (2000 onwards) set out a framework for analysing markets and identifying how they might better serve the needs of the poor. The MeTA concept was conceived to be consistent with the M4P framework by specifically addressing the need for more information and greater transparency to make medicines markets function better and be more accessible for the poor.

DFID, supported by the then Minister, had a strong focus on governance issues and recent experiences with the Extractive Industries Transparency Initiative (EITI) led to the proposal that a similar initiative be undertaken in relation to pharmaceuticals. This was a response to commitments made in the 2006 UK international development White Paper to transfer lessons from EITI to other sectors, and specifically to the health sector.

There was, however, a recognition that the EITI was undertaken in a very different context and some key players expressed doubt whether it could translate into an environment as complex as pharmaceuticals. There was a feeling that whilst EITI was primarily to use transparency to address corruption, the major problems in gaining access to medicines related to systems and the issues were already well known even if

the solutions proved elusive. This is not to infer that corruption is not an issue in medicines.

EITI incorporated leverage on industry through country validation, which, by indicating a transparent business climate, could theoretically lead to increased foreign investment. However, for the foreseeable future, MeTA was not seen as a way of formally recognising this commitment to transparency by any form of accreditation or validation. It was therefore important to find a way of encouraging the involvement of key stakeholders, for whom the benefits were less tangible.

Based on the EITI experience, it was felt essential to engage the pharmaceutical private sector. The view was taken that the market could not be made to achieve better access without both national and international private sector players. A significant shift in thinking was occurring in the international manufacturing private sector at this time following the events in South Africa involving GSK and issues around the drug paroxetine. This had highlighted both issues relating to using trials to extend patent and also the role of key opinion leaders (doctors and academics) in drug promotion. As a result there was increasing interest in reputational risk and social responsibilities but also there was considerable interest in emerging markets and some MeTA countries were classified as such. It could be suggested that there was a leap of faith in including the private sector when previous similar initiatives had worked solely with the public sector and CSO's but it was felt to be essential given the sector's propensity in developing country pharmaceutical sectors. MeTA was designed as a pilot for a new model of multi-sector stakeholder involvement and the risk was recognised.

The World Bank also had high level commitment to work in governance and having them as part of the Alliance was perceived to add their expertise in this field.

WHO had undertaken much of the predecessor work and had a considerable interest and expertise.

4. Major global issues in respect to Access to Medicines

Reliable access to high quality and affordable medicines is a core component of a functioning health system. Data from 27 developing countries show that average availability of essential medicines in public sector facilities is just 34.9%. This lack of medicines often drives people to the private sector where availability is better (63.2%), but prices are often unaffordable (MDG Gap Taskforce 2008). The poor availability of medicines in developing countries has many causes: insufficient and inequitable financing, weak supply chain and data management, leakages and diversion (i.e. theft and the use of public sector drugs in the private sector). In addition, when people do access medicines, WHO estimates that up to 50% may be inappropriately prescribed or dispensed (e.g. the wrong medicines or over-prescription of unnecessary medicines). In some countries, notably Peru and the Philippines there are major problems with counterfeit drugs and in others substandard drugs may be entering countries illegally ("suitcase salesmen).

This results in wasted resources, poor health outcomes and potential harm (e.g. development of drug resistance). Lack of good management information and information asymmetries (e.g. between manufacturers and purchases or prescribers and patients) have been identified as important factors that exacerbate the poor performance of pharmaceutical sectors in developing countries.

5. Previous and other current global initiatives in this field

There have been a large number of initiatives related to improving access to medicines. MeTA is but one player in this field and in some countries is working alongside both country and development partner funded work in this field. Where large projects (such as Securing Uganda's Right to Essential Medicines(SURE in Uganda) are operating it may prove more difficult to engage Ministries of Health. However, much work can be viewed as complementary including WHO's Good Governance for Medicines(GGM) GGM is currently working in more countries than MeTA but it has not yet been able to fully demonstrate it's impact, not least because no countries have yet proceeded through all three phases. There is the potential for a degree of overlap in the first two stages of GGM but the corruption focus of GGM is narrower than MeTA .

GGM does not operate in all MeTA focal countries. In the Philippines MeTA and the GGM have virtually merged. However this level of co-operation is only exhibited where active communication has forged the relationship.

A summary of current initiatives can be found in Annex 2.

5.1. Predecessor Project

MeTA builds strongly on the Regional Collaboration for Action on Essential Drugs in Africa Programme (DFID funded) which commenced in 2002. This was an initiative involving WHO and HAI Africa working together with the aim of increasing access to quality essential medicines in countries. Its focus was to bring the Ministries of Health/ public sector together with civil society to increase transparency and efficiency of countries medicines policy and pharmaceutical sector systems. Working groups were established in countries with the involvement of the MOH, Civil Society and WHO to plan, coordinate and monitor activities in line with MOH strategic priorities. This programme came to an end in 2008 with a positive evaluation and META was perceived to be a successor programme.

As part of this initiative, a network of National Professional Officers was established. These proved very valuable and, when the programme finished, funding for the NPOs continued with EC funding. This comes to an end in September 2010 and no future funding stream has been identified. Whilst MeTA (direct from DFID to WHO) is funding an NPO in Peru and the Philippines and a Medicines Advisor in Jordan plus a consultant in Kyrgyzstan, there is also currently considerable input from these EC funded NPOs. The WHO work contributed to MeTA as predecessor working groups were established and stakeholders sensitised, civil society organisations received capacity development and information started to be collected on a routine basis (e.g. the quarterly price surveys in Uganda).

However, MeTA was structured differently and private sector involvement was less attractive to the previous partner organisation. In addition, unlike in the predecessor

work, MeTA country multi stakeholder fora were not automatically led by the MOH and this appears to have resulted in some tensions with some of the MOHs being less prepared to be actively involved (e.g. Ghana). It is recognised that, likewise, hosting a multi stakeholder initiative in a public sector institution might also give the wrong messages to the other two sectors or affect the power balance within the national council.

5.2 Current Initiatives

5.2.1 Good Governance for Medicines Programme

The Good Governance for Medicines Programme (GGM) commenced in 2004 in line with the WHO Medicines Strategy 2004-2007. It has been funded by AusAID, DFID, Germany and the EC. It is working in 26 countries in line with the following model

Phase I	Phase 2	Phase 3
National Transparency Assessment (vulnerability to corruption in key system functions)	Development of a National GGM Framework (based on national consultation involving validating assessment results and identifying system development/ change necessary for good governance	Implementation of Framework (increasing awareness. Strengthening integrity systems and capacity building)

GGM has a specific focus on preventing corruption and has developed an assessment instrument covering eight functions as well as a model of good governance. It focuses on processes which are vulnerable to corruption and thus has a narrower, although potentially complementary, remit than MeTA.

GGM and MeTA both operate in the Philippines, Jordan and Zambia. The level of co-operation is variable. It is disappointing that whilst in Jordan that there is common representation on the GGM working group and MeTA Multi Stakeholder forum and an integrated workplan and in the Philippines the two initiatives work in a seamless way, in Zambia there is very little evidence of working together. Unlike MeTA, there is no requirement for the private sector to be involved in GGM although there is representation in some countries.

GGM is perceived to be complementary to MeTA albeit with a specific focus and there is evidence that the two initiatives have worked together in some (but not all) countries and internationally to build on this. Evidence includes:

- A joint statement from GGM and MeTA on their respective and complementary roles (available on the MeTA website)
- Joint visits to some common countries (e.g. Jordan)
- Collaborative initiates (e.g. the GGM award ceremony at the Philippines MSH forum in January although it should be noted that the visits associated with

this collaboration exert a significant cost on MeTA)
- Joint sensitisation and advocacy (presentations at WHA, lunchtime seminars in WHO)

GGM is involving key stakeholders of the pharmaceutical sector at national and global levels. In countries where it is implemented, national GGM programme are seen to serve as a good entry point for the promotion and implementation of the goals of the MeTA initiative, under the overall leadership of Ministries of Health in countries. However, GGM appears to be based on an approach which exerts moral pressure to identify and remove corruption rather than engaging all players to change systems in a way that provides benefit to them all and increases accountability to the end user.

5.2.2 Survey Instruments

In recent years, WHO has improved Level 1 and Level 2 survey indicators and tools for assessing countries pharmaceutical situation. In addition, methodology and tools were developed for measuring access to medicines through household surveys. The 2007 WHO Level 1 survey aiming at assessing pharmaceutical sector structure and systems in about 193 member states is being carried out. During the biennium 2006-2007; support was provided to about 30 countries to monitor the pharmaceutical situation using WHO Level 2 indicators and tool. This information and the tools are now available to MeTA.

Surveys on medicines prices, availability and affordability have been carried out in about 50 countries using the WHO/HAI Methodology. Tools have been developed by WHO to study prices components and for country monitoring of medicines availability and prices. A number of countries in Africa e.g. Ghana, Kenya, Tanzania are carrying out quarterly monitoring with the support of WHO and HAI Africa.

Key Findings

MeTA builds strongly on the Regional Collaboration for Action on Essential Drugs in Africa Programme (DFID funded) which commenced in 2002. It has used the survey tools developed in this programme and learnt lessons relating to the creation of National Professional Officers in national WHO offices to provide support. MeTA has synergy with the WHO Good Governance for Medicines programme but the level of collaboration with GGM both nationally and internationally, is variable.

6. The MeTA Pilot Phase Evaluation

MeTA is based on promoting transparency and increasing mutual accountability in order to increase efficiency using a whole market approach. The MeTA evaluation was based on addressing the following hypothesis:

Countries can establish functioning multi-stakeholder groups to agree plans for the generation and disclosure of robust policy relevant information on the price, quality, availability and/or promotion of medicines.

MeTA has built capacity to and resulted in the disclosure and scrutiny of relevant and high-quality information on the price, quality, availability and/or promotion of medicines

MeTA has facilitated the development of informed proposals for changes in policy and business practices

The current phase is perceived as a pilot so it has never been envisaged that all three parts of the hypothesis could be proven in the initial two year period. Given the relatively late launches in some countries, the review has largely focussed on process and potential rather than outputs at this stage.

7. Designing the MeTA initiative

The MeTA design process was relatively complex and took a considerable period of time. It was made more challenging because MeTA bridged two departments in DFID, Health Services Team and Business Alliance Team. Even after several years, perceptions about the genesis of MeTA vary considerably.

The concept of MeTA was generated, in part, from the EITI but it is evident with hindsight that the two departments had slightly different perceptions of the scope of the initiative. There appears to have been a lobby who believed that there should be focus on galvanising supply chains with a health systems emphasis but others, supported by WHO, believed that the focus should be governance. Originally a research network was incorporated but, as available funds were constrained this was removed on the basis that it could be provided on a "stand alone" basis with alternative funding. After extensive consultation, this eventually took the shape of a DFID grant to the Alliance for Health Policy and Systems Research to fund access to medicines-specific research.

During the formation of MeTA, consultation and scoping was extensive and involved a wide range of key players in interviews and consultation meetings. There was, however, quite a long period of time between the original scoping and the official launch which meant that stakeholders changed. Lessons were learnt from the EITI experience and the academic material which was emerging fed into the process.

The design, which involved extensive consultation undertaken with the support of HLSP, was undertaken by three individuals but they did not remain in their positions so the initiative was "inherited" by their successors. Again, this inevitably meant that there were further slightly different emphases in understanding. It may be these changes over time which have contributed to the number of logframe iterations. The project is now working with a third version which is coherent with the new DFID standardised template. No baseline was incorporated in the original design phase. Hence, the current baseline activities will provide countries with tangible information but will also provide a baseline for future evaluations

The originators of the initiative expressed a wish to manage the pilot phase "in house" but this was not possible with government constraints on "head count" and the secretariat function was therefore tendered. There is a recognition that insufficient efforts were made to generate interest in the contract and the response was disappointing (only two applications). It is perceived that, whilst the tender procedure complied with EU tendering requirements, the documentation and the subsequent contract had a number of inadequacies including some omissions of necessary activities, unrealistic budgets and timescales for some functions and the lack of a formal inception period. **Should the secretariat function be subject to tender under a second phase of MeTA, it is suggested that wider communication is used to obtain a wider and thus more competitive field**.i.e. that there is active targeting of invitations to tender materials to potential contractors and that advertisements are placed and timed for maximum impact.

7.1 Country Selection

It proved very difficult to identify how country selection took place but it seems that there was a positive decision to have one country in each of the WHO/ WB regions (excluding SEARO). The Alliance members, led by DFID, drew up a shortlist and countries were approached to ascertain their interest. There was originally a wish to have participation from one francophone country but this did not transpire. If countries expressed interest, a scoping exercise took place. These scoping reports were reported to lack consistency and quality and there was no common template.

There was an expectation that not all countries identified would proceed to be part of the initiative but in fact all did and one additional country was added at the strong request of the DFID Health Advisor locally. This resulted in the initiative covering seven countries in total which, even then, was felt to be over ambitious. There was a perception that there would be advantages in having both low and middle income countries as they could provide support to each other and benefit from cross country learning. However, lack of overlap with DFID country offices and limited country office support meant that there was limited institutional leverage in countries.

Although the initial contract for supporting MeTA did recognise the need for translation given the number of languages used by countries, this element was not substantial. **The absence of translated materials and the use of English for all international meetings is perceived as a significant problem by some countries. If MeTA continues and additional countries are recruited a simple cost-benefit analysis needs to be undertaken on including new countries whose working language is not English and the need for translating material including tools. However translating into Arabic, Spanish and Russian would widen the potential pool of countries who might wish to be involved.**

7.2 The Contract Process for the Secretariat

It is evident from all parties that the contract process was not without difficulties. It would seem that DFID staff were overcommitted at the time and the tendering process was not given sufficient thought. The contract did not include responsibility or financial provision for the initial launch and this caused delays and tensions. In addition there was some confusion between DFID London and DFID East Kilbride which resulted in changes to both budget and required deliverables. In addition, there was no inception phase and this meant there was inadequate time for setting up basic system infrastructure. The problem was exacerbated by the need to substitute senior consortium staff based, in part, on performance of the interim Executive Director.

The contract was set up as a fees and service based contract which appears to have resulted in some perverse incentives. It would probably have been preferable to have included some element of payment for output although, given the ambitious scope of the project and the short timeline, a purely output based contract would probably have been commercially unattractive at that time as potential contractors may have felt that the risk was not adequately shared and that delivery of some outputs relied very heavily on delivery which was not wholly in their control.

Key Findings

MeTA built on the principles of preceding work including EITI. The design work incorporated much consultation and scoping but was lengthy. The selection of countries and the number of countries chosen was probably ambitious for a pilot phase. Given the range of national languages more resources were desirable for translation and interpretation. There are lessons to be learnt from the contracting process.

8. The Alliance

8.1 Setting up the Alliance

It was originally the intention that DFID would be only one of multiple funders for MeTA and discussions took place with both the Dutch development agency and the Bill and Melinda Gates Foundation but neither agreed to support the initiative. The current Alliance involves the WB and WHO but the current leaders from the three organisations differ from those who formed the Alliance.

The design process did not have significant involvement from the WB but WHO worked on both the design and predecessor projects which shaped both the content and the countries which were chosen for the pilot. Whilst all alliance funding originated from DFID; the World Bank and WHO were involved from an early stage with agreements for funding for complementary activities. This alliance was based on formal agreements (an MOU with WHO and an EFO with the Bank).

WHO and the WB are members of the MeTA Management Board (MMB) and also have representatives on the IAG. From a governance point of view this is unusual and other members of the IAG find it confusing even though both organisations have different members on the two bodies (one to provide strategic advice and one to be engaged with operational matters).

8.2 Identifying a vision

The current Alliance members on the MMB do not all feel that they have had the opportunity to debate the MeTA concept and their respective positions on the hypotheses. There was a meeting in October 2009 to review the hypothesis and get buy in but there remain some significant differences of opinion and approach. Some of these differences reflect the individual organisational ethos but there remains a danger that the alliance partners together with the IMS, both at international and country level, could fail to provide a consistency of message and approach. This should have been identified and followed up by the communications team.

It is clear that there are differences of interpretation on the need for the multi-stakeholder fora in country and particularly the role of the respective Ministry of Health in these. Likewise there are differences in emphasis as to how changes in policy are most likely to come about. It is important that the Alliance is seen to convene around a common philosophy and methodology although this does not necessarily mean pursuing a common agenda in each country.

It is strongly recommended that any future Alliance has the opportunity to confirm both the core principles of MeTA but also to resolve any differences in emphasis and approach. This will be particularly important if there are additional funders, if MeTA is rolled out to additional countries or if support structures change.

The MeTA Secretariat likewise should be providing this clarity of vision and ensuring it is

consistently expressed in a wide variety of locations and materials (international meetings/ website/ annual report/ MOUs with countries etc). It is of the utmost importance that there is clear leadership and that there is consistency across all secretariat members. This requires excellent communication and constant quality assurance of all messages which come into the public arena. This has been raised by DFID with the IMS and specifically the communications team but the response appears to have been inadequate.

Whilst the current website is well designed and maintained, the home page does not articulate the MeTA hypotheses and merely provides a list of general "benefits" which MeTA would like to achieve without explaining how this might be achieved or MeTA's distinct and specific contribution. There are many players in this field, many of whom have similar aims and greater levels of funding. **If MeTA is to obtain additional support, it is of the utmost importance that it articulates it's unique, precise and catalytic role.**

8.2.1 Ownership and Leadership of the MeTA Concept

Any initiative of this magnitude needs to have clarity about ownership and leadership. At the present time ownership appears to be shared amongst several parties and there is not adequate clarity about what decisions can be made by each of them and what degree of self determination is accepted.

DFID was the originator, designer and funder. DFID continues to chair the MMB and is clearly extremely influential. Leadership within the Alliance, perhaps inevitably, comes from DFID given that the other two partners are receiving MeTA funding from DFID. Much of the drive to hold the IMS to account comes from DFID and this is inevitable given the contractual relationship. There appear however, to be some differences of opinion about some parts of the MeTA concept

The IMS is, for many countries, the public face of MeTA but they have not presented a united front. All members have "ownership" of MeTA with great personal enthusiasm but there are differences in perception. There does not appear to have been clear, cohesive, internal leadership. Although there have been changes in management as a result of poor performance, there is still a lack of systems to ensure clear, consistent, compelling external communication and leadership is lacking to establish and enforce internal systems for performance management and internal communication.

The IAG is an advisory body and, although there is good evidence that members "own" the MeTA concept, they have limited interface with other stakeholders apart from through their members including country representatives. They have the potential for both an advisory and influencing role but, again, perceptions of what is the essence of MeTA vary.

Whilst all countries have signed up to accept the basic principles of MeTA it is clear that the concept is not yet fully and sustainably embedded in all countries. Part of this is because, in the absence of clear communication, there are differences of opinion about what are the essential elements of MeTA. Leadership of the country initiatives varies significantly between countries. In Peru, much of the leadership comes from the small

executive group but, in other countries, it may be the Chair or possibly the co-ordinator. However in some places (notably Zambia) the national consultant still performs a strong leadership role which is probably inappropriate.

There appears to be a need to resolve the extent to which countries are buying into a standardised initiative and the extent to which they have the freedom to determine their own way forward. The IMS seems largely to have taken the view that support is available but it is up to countries to build up their own systems and learn lessons in the pilot phase. Support was available but not uniformly accessed. There has been a positive policy towards a bottom up approach and this has led to a variety of models. The view was taken that this would increase ownership and, indeed, in some countries, that has been the case but these tend to be the countries with more developed infrastructure and stronger capacity. However, inconsistencies have already arisen for instance when Peru decided to modify one of the information collection tools.

This approach may be partly the reason why workplanning has taken so long in many countries, as has setting up institutional arrangements. Whilst the IMS has been facilitative it has perhaps not felt able to find an acceptable way to support the process with both technical input but also clear expectations of what is required to obtain funding and what activities are an integral part of MeTA. Despite the approach taken, at least one country feels that the baseline activities have been "imposed" and this suggests that communication was not adequate during the early stages.

It is difficult to judge whether the "hands off" approach has resulted in greater ownership. Certainly, in at least three of the countries, MeTA is judged to not yet have achieved a state where it would be sustained for the future without external funding. It would appear that, regardless of the benefits, the approach has resulted in both delays and significant underspending as a result.

This does not argue for a "project management " approach as such but it does suggest that there are clear mutual understandings about:

- **Expectations of what common activities and approaches will be undertaken**
- **Where there is an expectation of conformity (e.g. the MSH approach) and what should be subject to local determination**
- **What resources are available to support this (from the IMS, the World Bank and WHO**
- **Timescales and milestones which all countries need to meet**

8.3 Funding the Alliance

8.3.1 World Bank

The EFO with the WB was for a sum of $920k in two tranches. The EFO is a flexible mechanism for funding which can be undertaken swiftly with relatively little bureaucracy. The modality involves significant flexibility and the aim was for the WB to provide support both in countries, through the Task Team Leaders (TTLs), and for international events (the Flagship course). Disbursement was tied to fiscal years which was potentially

limiting although brokerage between years one and two proved possible.

The country level support depended on TTL buy in to the MeTA process and this does not appear to have been achieved universally. Indeed, whilst the WB provided funding for the Jordan workshop and has supported a work stream relating to drug quality in Ghana, there is no engagement at all in Uganda (or Peru) and the country health advisor is clear that it is not a country priority. Although he confirms that funds are available, there is no encouragement to utilise these.

The MeTA process is synergistic to other WB initiatives including work related to Malaria in Zambia, Good Governance and Pharmaceutical Programme (University of Toronto) public sector drug supply in the Philippines and there is an appreciation at central level of the opportunities this provides.

Whilst there appears to be commitment at central level there is relatively little involvement at country level (e.g. not all WB local officers take up their seats on MeTA councils) and there appears to be no easy mechanisms for following this up (see Section 12).

8.3.2 WHO

DFID were understandably keen to engage WHO in META both for its history of working in the field of medicines and its current work but also for its convening ability both internationally and nationally. WHO perceived MeTA as coherent with their principles relating to transparency and good governance but also in line with human rights approaches. Increasingly WHO is a project funded organisation (only 8% of the Essentials Medicines directorate is core funded) but the WHO HQ Director was prepared to invest some "risk capital", over and above the DFID resource, if necessary (see Section 12).

Key Findings

It is important that all Alliance members have a common vision of both the principles and implementation methodology of MeTA. Whilst country ownership is essential, it is necessary to have clarity about

- **Expectations of what common activities and approaches will be undertaken**
- **Where there is an expectation of conformity (e.g. the multi-stakeholder approach) and what should be subject to local determination**
- **What resources are available to support this (from the IMS, the World Bank and WHO**
- **Timescales and milestones which all countries need to meet**

The MeTA Alliance is currently solely funded by DFID with some funds channelled through the World Bank(WB) and WHO. WHO has valuable technical expertise, good convening presence in countries and responsibility for both predecessor programmes and current complementary initiatives. WB has synergistic expertise particularly relating to governance and finance. With both the WB and WHO there is strong central commitment to MeTA but engagement locally cannot be assured. This is unfortunate given their presence in all countries.

For a project which has transparency at its core, there does not seem to be widespread knowledge of the total allocations (including those to the WB and WHO) and the proportion controlled by country multi-stakeholder fora is small. It is strongly suggested that, should MeTA 2 proceed, then serious consideration be given to the allocation of resources between national and international initiatives.

It is equally important to ensure greater transparency about the totality, allocation and source of resources, how these may be accessed and who makes the decisions at which levels,(MMB, International Secretariat, Country Council, Country Secretariat).

9. The MeTA Management Board

The current MeTA Management Board involves both alliance partners and members of the secretariat. WHO and the WB to some extent fulfil a dual role as they are both alliance partners and receive funding to support MeTA work both globally and in countries.

The current MMB structure is unsatisfactory in that it is unable to perform a governance function. Alliance partners should

- Identify the overall direction of travel for MeTA, advised by the International Advisory Group (IAG)
- Take major decisions on priorities and funding (as laid out in the workplans)
- Hold the Secretariat to account for the day to day operation of MeTA using the workplanning and monitoring processes (using an agreed data set and frequency)
- Hold other grantees to account
- Agree the extent of delegation and virement given to the Secretariat
- Have an overview of progress of MeTA both globally and locally

In practice, the MMB is spending a disproportionate amount of time on function three; receiving detailed monitoring reports and undertaking detailed workplanning. Whilst this has reduced to some extent recently it has dominated discussion and created major transaction costs. The MMB meets regularly and attendance is good but it appears to be too absorbed in the minutiae and is thus less able to discuss major strategic issues. Thus, whilst DFID is currently undertaking informal discussions to seek new alliance partners, there has been little debate about who these should be and the implications that may arise by including, for instance, private sector funding.

Monitoring has been unusually detailed and this appears to stem from confidence in the secretariat being diminished when agreed actions and activities did not materialise. It is clear that the Secretariat was failing to deliver, particularly in respect of communication activities, but other routes for addressing this were possible including the contractual options. The increase in monitoring, although ultimately effective in addressing some issues, appears to have created something of a vicious circle with an increased frequency of formal monitoring reports creating significant work for the secretariat which, in turn, has diverted them from project delivery. The lack of established and demonstrable performance management systems (i.e individuals being held to account internally for delivery) has exacerbated the situation. Reports have been produced fortnightly (at the initiative of the IMS), monthly and quarterly and this has been supplemented by telephone progress meetings. Not only has this had huge transaction costs for the secretariat but also for DFID who have been intimately involved in decisions relating to delivery.

It is interesting however that, despite all these monitoring activities, there has not been much attention given to value for money (VFM). There are areas where the expenditure, though small in overall terms, is causing comment because it seems extravagant. (e.g.

use of taxis, quality of hotels used etc) but more importantly **there is no routine retrospective cost benefit analysis of activities**. This should be incorporated so that (for instance) the costs of each of the Jordan courses, per participant, are known and the costs of international private sector engagement. Some evaluation of the cost effectiveness of short international technical support visits might also be appropriate. Although it is recognised that a fees and reimbursables based contract does not lend itself to this approach, some short VFM audits would seem to be desirable. Likewise a more detailed functional coding system would also support this.

If the consortium had greater professional management expertise this situation could have been avoided. There are proven skills in managing "upwards " (i.e in managing the relationship with contractor/ commissioner) but these were not deployed by managers of the consortium. Likewise, rather than becoming more involved in the minutiae, it seems probable that a harder contractual approach by DFID involving delivery of agreed milestones at predetermined dates was needed.

There is no clear separation of the governance function and the executive function in the MMB and the Alliance Partners do not meet separately to consider matters which would normally be reserved to them e.g. the performance of the Secretariat, future models for secretariat support, audit reports etc**.** It is clearly inappropriate that the existing Secretariat are involved in any way in discussions on the successor body both at MMB and IAG.

There is a recognition that the current governance arrangement both at Board and IAG are not satisfactory as evidenced by work commissioned to look at alternative models. This review has been carried out and the findings were presented at the January IAG. Whilst not wishing to propose a structure, discussions suggest that the following points need to be taken into account when considering the future of the Board.

- There needs to be a clear governance structure separate from the executive function which holds the executive (principally the secretariat) to account

- There should be clarity about what decisions the alliance members reserve to themselves and the constitution should enable the alliance board members to meet without the secretariat at regular intervals for prescribed purposes (possibly for a "Part 2" meeting following MMB

- Any governance structures needs to be simple and have the ability to make decisions without undue delay

- There needs to be both inclusivity and transparency in the decision making process. Alliance partners should be involved in strategic decisions and the process and outcome should be visible. (it was interesting that some country representatives on the IAG were unaware of the existence of MMB or its function)

- The work planning process should drive MeTA support and activities. There should be clarity about how much autonomy is given to the secretariat in terms of reallocation of funds and changes to the agreed programme.

Key Findings

The MMB does not have clear separation between the oversight body and the implementing body. The current MMB work has, by necessity, been heavily focussed on detailed monitoring of implementation activities by the secretariat which has reduced the opportunity for a more strategic focus. There is a recognition that governance arrangements need to be reviewed for MeTA 2.

10. The International Advisory Group (IAG)

10.1 Remit of MeTA IAG

There is a difficulty evaluating the IAG as there are a number of versions of its Terms of Reference in existence. The table in Annex 3 highlights these differences.

Terms of Reference (TORs) were circulated to IAG members before the first meeting and confirmed by the Chair. It is difficult to know precisely what was confirmed as the aide memoire which recorded that meeting differs quite considerably from the circulated TORs and suggests that the IAG will interface direct with countries.

At this first meeting the Chair also confirmed the advisory role of the IAG and the "ground rules" by which the meeting would operate. However, not all members were present and there is a perception from members that inadequate time was allowed for discussion to establish a clear understanding.

Prior to the IAG meeting in January 2010, it was evident that not all participants were clear about the role of the IAG, nor what outputs were envisaged. This may partially be a result of the confusion highlighted above but also may be because some members, particularly those representing countries, have not been able to attend consistently or because they were not identified until later than the first meeting.

Particularly amongst country representatives, there were substantial differences in perception about whether the IAG had management powers, together with a general lack of knowledge about the alliance structure as a whole, the respective roles of the three partners, the management board and the secretariat. Quotes relating to the IAG include

"It is the main decision making body"
"The IAG runs MeTA…it decides what should be done"
Country Representative

It is clear from discussion that many IAG members (including country members) do not have knowledge of all the resources available through MeTA at country level nor what support the country Councils and Secretariats have potentially available. Some have unrealistic expectations of what can be achieved in countries particularly about the capacity to influence policy and behaviour change given the demands on council members and the support available from Secretariats which can be as small as a single person.

If the present structure were to continue into a second phase, it would be important to confirm the exact role of IAG, what contribution it is being asked to make, what communication channels it has available and which bodies it should be interfacing with.

The IAG is constituted as an advisory body yet it is not clear whether it is advising the Alliance, the MMB, the secretariat or the countries. In many ways it is currently operating partially as a Board (which may explain members confusion as to role) and partially as a high level discussion group. **If it is to be truly advisory it is important to identify:-**

- **How is the agenda devised and who identifies topics on which advice is sought?**
- **If countries are to be the recipients of advice (as identified in one of the role descriptions) how do they articulate their needs?**
- **How does the IAG ensure that their advice is realistic and relevant and reaches the appropriate recipient?**

There is currently a major disconnect between the high level and somewhat theoretical discussion that takes place at IAG and the reality of the issues facing some national councils. In addition, the lack of effective mechanisms for transmitting the content of IAG meetings to a wider audience suggests that it is not adding as much value as it has potential; many stakeholders at country level were unaware of its existence. When asked what specific guidance or advice had been provided by IAG which had direct relevance to countries, none of the members were able to identify specifics.

10.2 Membership

The IAG consists of experts in the fields of transparency, pharmaceuticals and the drug supply chain, academia, the private sector together with country representatives. The means of selection are not completely transparent and non country members appear to have been selected based on personal knowledge of their potential contribution. All come from highly relevant backgrounds, however, and have the potential to provide good input to the MeTA process, both inside and outside formal meetings. It was intended that the IAG should mirror the multi stakeholder engagement being created in countries.

"IAG members have a great deal to offer us, they have seen the world"
Country representative on IAG

Members of IAG are not remunerated although expenses are paid. The Chair receives payment and is allocated a number of days in the budget. In year one these are understood not to have been used but in year two an additional contract was negotiated for work related to governance. This work did not form part of MeTA as such and was thus contracted separately. The original contract envisaged that the Chair would visit MeTA countries to identify issues where the IAG might contribute its expertise. It is not sure how realistic this was, given that she had a demanding full time job. Either way, this has not happened, although she has visited India with the ED to engage with private sector manufacturers.

The private sector in pharmaceuticals consists of a number of elements;- international manufacturers, national manufacturers, distributors, wholesalers, retail as well as private clinicians who prescribe and may also supply medicines. Not all of these are represented on the IAG and probably cannot be in a meaningful way. It is evident that manufacturers probably have the biggest incentives to be part of MeTA but may actually

be less critical in achieving the aims, particularly in country.

There are some topic areas which are not covered in the IAG however. One of the problems from conception is measuring the impact of MeTA and the pilot phase has been particularly difficult as it lacks a baseline. Identification of key information is key to the MeTA process. Clearly WHO brings considerable expertise in this field to the IAG and indeed many of the baseline tools have been developed/ used by them worldwide. **It is therefore suggested that it might be worth considering including a representative from their collaborating Centre with an understanding of the metrics by which META will be evaluated for impact,** such as a representative of the Harvard Drug Policy Research Group who has been deeply involved in the surveys being undertaken in countries. This would also provide a further link to similar in country work funded by other Development Partners including USAID.

Country representatives are members of the MeTA council in their respective country. Some are the Chair of the MeTA council but this is not universal and their seniority in country varies. Again, the selection process has not been standardised and, whilst they are ostensibly representing their countries, there is not consistently a system for discussing agendas in advance or feeding back discussion afterwards. Other in country council members appeared not to have detailed knowledge of the existence of the IAG nor of its function. **It is important that country representatives act as two way conduits, highlighting areas where countries require advice but also feeding back the discussions and conclusions from IAG.**

The makeup of the IAG, which has strong private sector participation, has given rise to some suspicion on the part of at least one country representative.

"The makeup of the IAG confirms that DFID are only doing this to protect the private sector, expose the informal sector and protect prices"

Whilst this perception is extreme and does not reflect the generality of attitudes, it is a reminder that there is deep seated distrust between sectors which will take a long time to break down and that, as yet, the IAG has not been able to deliver as a forum to accomplish this.

10.3 Meetings

The IAG has met three times in total. It was intended that the meetings should be held six monthly but the third meeting was delayed until January to allow a discussion of work prepared by the Chair on potential governance arrangements.

Attendance has been reasonably good although not all countries attended the first meeting and, indeed, some changed their representative. On occasions, it has been necessary for substitutes to attend.

There is a perception that agendas for meetings do not give adequate time for consideration in advance and that there is a lack of supporting information which would make discussion more productive. **It is important that use of this high level group is optimised and therefore agendas need to be circulated a minimum of seven days in advance together preferably with country reports and background briefing**

papers for discussion. If country level IAG members are going to have time to discuss them with colleagues, then even longer will be needed. It is also evident that much of the communication relating to IAG is actually sent out by the Secretariat and, on occasions, has not been approved by the Chair.

10.4 Current Content of IAG meetings

The first two IAG meetings included presentations from members including evolution of markets, multi stakeholder working, corruption issues and the role of CSOs in advocacy. These were chosen as they were seen to be central to MeTA principles.

Part of each IAG meeting is given to country progress reports. There is no formal agreed reporting format for this and it does not indicate progress against either the logframe (of which many IAG members appeared ignorant) or the workplans, nor does it give any feel for rate of spend against plan (which many IAG members would like to know).

These reports provide useful contextual information for non country members of IAG but the format is not designed to identify problems/ bottlenecks where IAG might contribute nor to analyse lessons learnt. Despite the advisory function of the IAG, the reporting format appears focussed on progress reporting which is much more suitable to the Management Board.

If the IAG continues to have an advisory role**, it is recommended that the format for these "reports" be changed so that the time is used for learning and development rather than progress monitoring.** This could build on the change in format at the third IAG and be through some form of reflective learning (e.g. presentations on successes and their contributory factors or indeed on things which didn't work and why). Countries could identify and present bottlenecks and challenges and the IAG could then use an action learning approach (i.e. using the Revens model) so that lessons could be abstracted in a dynamic way.

This is more challenging and requires considerable trust and confidence on the part of participants but, now that relationships have developed, it might be possible to refocus on the stated function of the IAG.

Non country IAG members bring huge experience and expertise yet many of them have no contact with MeTA outside formal IAG meetings. **Many of them would be prepared to make themselves available, to a limited extent, to provide knowledge or advice in their specialist area or to form small electronic working groups. There appears to be an opportunity for some form of mentoring or coaching using email or VOIP.**

IAG meetings are relatively expensive. Members attend from all over the world for a meeting which lasts not more than eight hours. They involve the cost of flights, hotel accommodation and incidentals. There is also the (considerable) hidden cost of the participant's time which, in most cases, is given free. There is huge potential expertise but at the present time this does not appear to be being optimised and there must therefore be a question about value for money.

10.5 Feedback to countries from IAG

Whilst country representatives have, in general, participated well in meetings it is difficult to assess the degree of feedback which is received in countries through them. In some cases it appears to be largely confined to a summary of the minutes and, in at least one country, it is difficult to identify whether it is taking place at all.

Key Findings

The role of IAG has not been sufficiently clear and both the advice required and the means for transmitting it need to be reviewed. There is huge untapped potential in the membership. The current format of meetings does not appear to give value for money

11. The International MeTA Secretariat (IMS)

Note; During the period of the evaluation issues arose between partners responsible for the Secretariat function. The evaluation team did not enter into discussion about the dispute per se but recognise that some of the material collected before the difficulties became public, may have relevance. After consideration, they are included in the review in the format that would have been used if no dispute had taken place. Indeed much of this section was written prior to mid February.

11.1 Formation of the consortium

The International MeTA Secretariat (IMS) function was, at the onset of the evaluation, delivered by staff from three organisations, Health Partners International (HPI) a private sector consultancy company, HERA (Health Research for Action) also a private sector consultancy company and Healthlink Worldwide, a not for profit company specialising in communication and development. The consortium was brought together with HPI designated as lead specifically to undertake this work and the partners had not previously all worked together as a contracted group. Whilst the disadvantages of being based in a number of locations were recognised, it would seem that this was not identified as central to the problem which has emerged.

HPI is the lead partner and holds the contract with DFID and has (had) two MOUs with the other partners

The IMS is perceived as including a number of people viewed as activists with NGO backgrounds. Their history of activism (some of which was many years ago) is still remembered by some of the key stakeholders and it is not clear to what extent it affects IMS's ability to function in some of the MeTA countries. Certainly this perceived historic loyalty, together with the focus on CSO capacity building with a separate budget, appears to have raised a degree of suspicion, if not distrust, in some stakeholders.

11.2 Contractual Processes

It is evident that the contracting process did not run smoothly and this appears to be a result, in part, of the original design not having taken into account all activities. There is a recognition that there were areas which were omitted (including the official, international launch, the baseline and the research network) and also under budgeting. This meant that negotiations and contract revisions were needed on two occasions in the first year which inevitably took up much time.

This is a fees and services contract. It was felt by DFID that the consortium did not initially have a full understanding of the implications of this and there were thus delays in setting up systems and ensuring that invoicing conformed to this model.

The contract, in effect, had no inception period as the new secretariat was required to immediately start arranging the launch. **Whether this should have been an integral**

part of the contract or whether the contractor should have factored it into their bidding approach is a matter of debate but the lack of this inception period for initial team building, ensuring commonality of understanding and approach, setting up systems and establishing robust communication and performance management has had a long lasting impact on the effectiveness of the Secretariat.

The balance of input in the IMS is fairly heavily weighted to administration, finance and logistics. Although a contract modification, requested by the IMS created an additional country support post, there is still relatively little technical input. This appears to be recognised by DFID.

11.3 Financial Issues

Whilst this is a pilot project with a focus on activities at country level in seven countries, a high proportion of the budget held by the consortium is designated in the contract for international events, support from the IMS and TA and reimbursables (flights, accommodation etc). Because of the changes in contract (and thus the associated budget) it is difficult to undertake an analysis of allocation and identify exactly what proportion benefited countries both directly and indirectly. Some of the fees and reimbursables relate to TA and other expenditure which directly affects countries. What is clear however is that, in year one the following outcome resulted.

Table 1. Breakdown of budget and expenditure, year 1

Budget Year One	% of total	%Spend
Direct Country Funds	14	15
Reimbursables	24	19
Total Fees	55	59
Management Fee	7	7

It is understood that, in Year 2, country funds account for an increased proportion of the total budget (27%)

For a project which has transparency at its core, there does not seem to be widespread knowledge of the total allocations (including those to the WB and WHO) and the proportion controlled by country multi-stakeholder fora is relatively small. **It is strongly suggested that, should MeTA 2 proceed, then serious consideration be given to the allocation of resources between national and international initiatives. This is particularly relevant when the evaluation has had difficulty ascertaining the contribution provided by the IAG to countries during the pilot phase and, despite much activity, there is no commitment from the international private sector.**

There is clearly a strong incentive to disburse to countries but this appears to have led to many countries receiving advances before previous allocations have been spent. Some of the countries have inevitably got plans which are “backloaded” but it would be interesting to know if there are perverse incentives involved in this “early disbursement”.

11.4 Staffing of the International MeTA Secretariat (IMS)

In the early stages of development of the IMS there were two changes at Director level, one being the replacement of the interim executive director by a new Executive Director (ED) with private sector expertise and experience and the second being the Operations Director. These changes reflected concern about performance issues

The IMS are not co-located and this inevitably makes communication and co-ordination more difficult and with higher transaction costs. It is clear that efforts are made but there has been the feeling that this is a group of individuals working together rather than a team. Communication between IMS members is perceived as poor and there have been very evident tensions.

The IMS come from different organisational cultures (the charity/ NGO sector, consultancy/ private sector) and, whilst this has considerable advantages in the experience they bring (and indeed it reflects the MeTA philosophy), it might have been worth investing more time in team building and understanding expectations, organisational values and ensuring a common "language". This is stronger within the "core team" but has caused some problems in the wider team where some individuals are part time and do not communicate a consistent message. It is understood that an internal workshop was held in March 2009 to facilitate this process but the outcomes are not felt by external observers to be apparent. This is an issue that should have been addressed by the lead partner.

Whilst the IMS appears to currently operate effective administration systems it was not set up with a unified performance management system and accountability lines are through the employing companies, not from the ED and through the Directors. The Directors have recently developed a "decision tree" or "schedule of accountability" but this is not yet known throughout the organisation. It is not clear to employees how for instance, grievances or poor performance would be formally handled. **The IMS has no system for cascading objectives (including budgets and timelines) to individuals and this would support timely delivery. The organisation would be an obvious environment for a 360 degree style of appraisal at all levels and it is recommended that this is considered for all IMS staff.**

Despite contracts of employment being through the partner organisations staff, in general, felt that remuneration and conditions of service "felt fair" and there were not perceived problems with comparability in respect of leave, conditions of service etc. There was a feeling however that some staff operated in a mode more akin to consultants whilst others worked as employees.

The Secretariat has experienced some significant changes in staffing over the two year period with both the interim Managing Director and the Operations Director being replaced based on performance issues. In addition one other Director has been on long term sick leave.

A new Executive Director (ED) was brought in from the private sector. It was intended that this would both strengthen internal management processes but also provide focus to private sector input within MeTA. These two roles require very different competences.

There is a perception that this has not worked out as well as intended. Although there has been stronger engagement with international companies including some of the well regarded generics manufacturers, the overall management role has been less successful and the secretariat still appears to lack a clear framework for engaging the private sector. The ED's management style is perceived (and has been observed) as reactive and is felt to lack a credible overview of the work as a whole. One of his key deliverables has been a private sector strategy. This has now been through a large number of iterations but it is felt that it still does not demonstrate clarity about MeTA principles.

The ED has had extensive contact with the private sector but it is not clear whether he has been operating at the appropriate level and with the appropriate organisations and whether he has communicated a convincing vision of the potential of MeTA. There is a feeling that whilst major international manufacturers may be prepared to be more transparent (although there needs to be greater clarity about precisely what this will involve), and this accords with their social responsibility programmes, the benefit in respect of access to drugs will probably be found elsewhere in the private sector, particularly in countries.

The Technical Director has travelled extensively and has an overview of progress in all countries both in terms of work plan deliverables but also in terms of the technical context. Relying so heavily on one person is probably not tenable in the long run and constitutes a considerable risk. A second country level support post was created but much of the capacity of this post is focussed on administration. In addition, the span of contacts is almost certainly too large for effective communication. He is not employed full time on the programme and this inevitably has, on occasions, resulted in conflicting demands on his time.

The Director of Operations is widely perceived as very effective and has excellent communication skills. She and her team form the full time core of the Secretariat.

The Director responsible for Communication and CSO support has been on extended sick leave. He is recognised internationally as an expert in his field and has undertaken two regional MeTA workshops for CSOs together with a number of national initiatives and support to CSO workplans and these have been reported to be useful in bringing CSO organisations in country into co-ordinated consortia. However many of the overall areas where the consortium is perceived to have performed poorly relate to communications and, to a lesser extent, to support to civil society capacity building. The lack of a credible and comprehensive community strategy and the lack of internal and external clarity on the basic MeTA principles has clearly been a major matter of concern.

Key Findings

The IMS has given cause for concern, particularly in respect of leadership and the communication function, and is perceived not to have performed well. The lack of a credible and consistent communication strategy has been a major shortfall. The staff are not co-located and some are part time and there is no team wide performance management system.

However, technical input has been well received and the operations function is well regarded. The balance of staff between technical and administrative appears inappropriate for the task. Given the large proportion of the budget which is held by the Secretariat, it is important to agree clear measurable outcomes for their work and to ensure value for money.

The current financial reporting does not facilitate cost benefit analysis by activity. Allocation of time by the secretariat by country/ function is not reported and it is not possible to easily calculate the totality of input into a given activity or event.

11.5 Engagement with the Private Sector

The basic hypothesis of MeTA involves engaging with the private sector at international and country level. At international level, the definition of private sector translates as (mainly manufacturing) industry although at country level the definition is much wider and may include manufacturers, importers, wholesalers, distributors, retailers and clinicians working in private practice. Not all country level councils have representatives from all parts of the private sector.

Table 2 Breakdown of Private Sector representation on country level MeTA councils

Country	Importers	Wholesalers	Retailers	Clinicians	Local Manufacturers	External Manufacturers
Ghana	Yes	Yes	Yes	Yes	Yes	No
Jordan	No	Yes (incl in Pharm Assoc, representative)	Yes	Yes	Yes	No
Kyrgyzstan	Yes, combined role	Yes	Yes, combined role	Not from private sector	No	No
Peru	Yes	Yes	No	Yes	Yes	Yes
Philippines	Yes	Yes	Yes	Yes	Yes	Yes
Uganda	Yes	Yes	No	No	Yes	No
Zambia	Yes	Yes	Yes	Yes	Yes	No

Source . Report Feb 2010 with country verification

Note: Clinicians may be represented by their professional body or by an umbrella provider organisation and wholesalers, importers and retailers may be represented by industry groups in which manufacturers are more influential.

It is widely suggested that there are more incentives at country level for manufacturers to endorse MeTA principles and become involved than for other players in the supply chain. The feeling is that wholesalers, distributers and retailers may be making the biggest “mark-up” and may not wish to disclose this. There are examples however of initiatives which are in line with MeTA. For instance the Africa Affordable Medicines retail

chain in Uganda and Medical Access Uganda Limited (MAUL) which proves affordable ARVs through a procurement, distribution and retail process based on "open book" margins for the companies involved. In the Philippines, there is 'Botikang Barangay' – a chain of around 15,000 private community pharmacies carrying a range of essential drugs, accredited and supplied (at low prices) by PITC and other suppliers.

Major manufacturers are not represented on all MeTA councils and there is a suggestion that they may be discouraged by local interests. Where there is a move towards more stringent policy on the use of generics there is widespread speculation that they may wish to be involved to protect their interests.

At international level, the private sector is well represented on IAG although there are no country level manufacturers or clinicians (and this appears to be where most potential resides).

At an early stage there was a recognition that the IMS required greater expertise in the private sector field and a new ED was recruited with this remit. He was tasked with producing a strategy and a work plan. It is clear from the documentation that there have been numerous iterations of a MeTA Private Sector Strategy since that time. A draft was presented to MMB in February 2009 and to IAG in April 2009 and the most recent was circulated in February 2010. It might have been worth considering forming a sub group from IAG to support the development of this strategy.

The benefits to industry were identified, as well as the potential threats of not being involved. The main aim of the international private sector engagement exercise was *"to solicit the public endorsement and support for these rationale and principles relating to transparency and engagement from*

- *international representative organisations of the pharmaceutical industry other relevant international private sector representative organisations*
- *individual pharmaceutical companies, both proprietary and generics at corporate, international and regional levels."*

A further aim has been for the endorsing companies to work with private sector colleagues at country level.

Considerable efforts have been made to introduce the concept and the potential benefits of engagement to pharmaceutical companies and a conference, "Levelling the Playing Field " was held in June 2009 at which 30 companies attended.

So far (Feb 2010), no companies have given formal endorsement to MeTA although some have expressed interest and there is little or no evidence of major engagement by international companies at country level which can be attributed to MeTA. There does however appear to be interest in the standardisation of codes of promotion as international manufacturers perceive that country codes are less strong than those agreed by international pharma. This low level of achievement is disappointing given the substantial input. There has been a large volume of activity, including meetings with Associations representing the private sector as follows:

Table 3. MeTA meetings and contacts with private sector bodies

Association	No of meetings and contacts
ABPI	5
IFPMA	7 (plus rep on IAG)
PhRMA US	1
APG	4
EGA	5
Indian Manufacturers	4
AFID Turkey	2

Source Feb 2010 report

Three of these associations have indicated a willingness to endorse (Feb 2010). This has involved visits to India, the US, Europe, with one visit also involving the Chair of IAG.

In addition, meetings have been held with thirty seven pharmaceutical companies. Of these, four have indicated that they would be willing to endorse MeTA principles although no actual confirmation exists. One of the issues raised by interviewees is that it is not clear whether contact is being made at a high enough level.

"We can engage with people in companies easily but are we engaging the companies?" IAG member"

These meetings have undoubtedly raised awareness of the MeTA name and given a broad understanding of the aims. However, whilst there is still a lack of clarity on exactly what endorsement will involve, it is not surprising that this has not been achieved. Documentation over a very long period of time records the need to identify compelling messages and agree what data should be disclosed and exactly what disclosure will involve.

Whilst there has been significant debate at both international and country level there appears to be a lack of detailed analysis. There is felt to be almost a degree of naivety in the key messages which ignore the complexities and variations. **There has been little detailed debate on the potential legal implications of disclosure nor the costs of making information available on a routine basis indefinitely. Independent quality assurance will be needed as well as agreement exactly how this information will be collated, stored, updated and made available. Making unverified information public in a number of unrelated locations on an ad hoc basis will not be enough.**

MeTA itself does not have the leverage to get people to the table so there is a need for a compelling vision. This requires work between the communications specialists and the technical/ private sector specialist. Unfortunately, the emphasis that is being given by stakeholders in some countries (notably CSOs and the public sector) is that MeTA is focussed on price. This is despite central messages from the IMS and others that quality and promotion are equally important. This is neither helpful for engagement with the private sector nor accurate; there are many other areas for private sector engagement with more opportunities. These include exploring the benefits of increasing quality control and the identification of counterfeits, increased understanding of emerging

markets, exploring alternative business models, group buying, rationalising private sector prescribing, streamlining the supply chain and obviously the political benefit of visible social responsibility and the opportunity to influence policy. MeTA is aiming to establish continuing and robust systems for gathering information in countries and it is important that all parts of the private sector chain recognise the potential "win;win" of this.

There are other incentives however; many countries already have preference rules re procurement and registration. Companies who are not sharing information could be 'unpreferred'. Companies are already providing much information for registration purposes and this needs to be used better. Uganda has made a start on this by making basic registration information public. WHO/WB and to a lesser extent DFID, also have the power to endorse company behaviour on the world stage which would be seen as highly desirable.

Private sector involvement is felt to be crucial at country level where the players are different but it is also highly desirable to obtain international endorsement. Once one company is prepared to endorse then others are likely to follow. This was the experience of EITI with BP and a similar "early adoptor" is needed to persuade international manufacturers that the exercise is worthwhile.

It must be recognised that there are significant differences between MeTA and the EITI on which it was modelled and EITI is at a significantly more advanced stage and the focus was on transparency round a single transaction. Even in EITI, private sector engagement and compliance is considered to be weak. At this stage, there is no intention to move towards country validation under MeTA. The EITI provided significant leverage to companies which wished to engage with candidate countries. Some, but not all, of the MeTA countries would be classified as emerging pharmaceutical markets and major manufacturers will have real incentive to engage with them and share information. However, there is no *requirement* to "sign up" to MeTA principles and **it will be essential to demonstrate that, on balance, endorsement and subsequent commitment to disclosure is worth while.**

One additional proposal that has been floated is to involve the private sector as a funder of MeTA. This was raised at the January IAG. A number of interviewees have expressed the view that **this has the potential to result in a significant conflict of interest (e.g. the independence of WHO in respect to assessing manufacturing units) and it is clear that it could even compromise the ongoing involvement of some key stakeholders (e.g. HAI).**

Key Findings

There has been much contact with major international manufacturers who have expressed interest in the MeTA concept. However, none had been prepared to commit at the time of the evaluation. This may be because there is still not a clear message being articulated about what they are being asked to commit to

11.6 Engagement with Civil Society

Most engagement with civil society has taken place at country level in order to ensure that they have been involved in the Multi Sectoral Stakeholder fora and have the skills to engage as equal partners. There was a recognition in the project design by DFID that capacity building would be required to support active and productive engagement. The aim has been to form coalitions of CSOs who will put forward representatives to councils.

Forming collaborations has had a degree of success but the concept is better developed in some countries than others. In Jordan the concept is very new and some bodies classified as CSOs in respect of MeTA Jordan might not be similarly classified elsewhere.

It must be recognised that CSO organisations may not have harmonious relationships and indeed may be competing against each other for funding outside MeTA.

A specific civil society capacity building workshop was held in the Philippines in 2008 to strengthen civil society engagement and a similar workshop was delivered in partnership with HEPS (the lead CSO in MeTA Uganda) in Uganda. These were delivered in collaboration with HAI and Soros foundation. These workshops appear to have covered appropriate topics and the evaluations are reasonably positive but the outcome of the Uganda workshop involved only five CSOs engaging with MeTA and adopting the principles (see Section 18)

It is not clear how much support has been provided from the IMS to CSOs on an ongoing basis. Whilst the responsible Director has made some visits to countries there does not appear to have been ongoing contact neither with national TA nor with lead CSOs.

At international level there has been strong representation from groups involved in advocacy, rights and transparency on the IAG Their contribution has been invaluable but, at times, there have been visible tensions between members and this may become more difficult if and when the IAG gets involved in providing advice on “real” country issues. This will need careful management and it is suggested that some “rules of engagement” may need to be negotiated to ensure that the activity is positive.

Key Findings

Achieving collaborative working between CSOs has been harder in some countries where there is less precedent. Workshops for CSOs have been seen as helpful but it is not clear how much ongoing support has been provided by the IMS

11.7 Communications

Up until the end of February 2010, Healthlink Worldwide had responsibility for the communication function. It is very evident from discussions that there has been a major lack of consensus between the stakeholders about exactly what communication is required and who it is serving. It is equally clear from interviews that there have been major concerns about the performance of the communication function. The evaluation has highlighted that MeTA currently lacks a clear vision which is owned by all partners and the IMS is not giving a clear set of compelling messages.

MMB meeting reports and evaluation interviews document the significant input made by DFID to address these shortcomings. This has had large transaction costs. The problem was exacerbated in 2009/10 by the absence of the Director on sick leave but it was clear that there were not even reliable systematic communications within the communications team itself.

Communication is not, however, solely the responsibility of a small group or an individual. It is of the utmost importance that there is consistency of message and that there is a regular and reliable flow of information using agreed systems. Whilst this needs to be facilitated by the communications lead, it relies on the IMS and TA working as a cohesive team.. Currently the key players are not imparting a consistent vision nor agreed key messages on what MeTA is trying to achieve. In part, this appears to be because there has not been sufficient time or opportunity to ensure that individual perceptions are aligned. This may be a result of inadequate inception time or lack of recognition of the problem. It is the responsibility of the ED to address this with support from the communication lead. **If MeTA enters a second phase it will be extremely important to designate both time and resources to achieve consistency of vision and agreed means of achievement with both new players and existing stakeholders at all levels.**

A draft Communication Strategy dated January 2010 has been made available to the evaluators but it is not clear what status this has. Given that this was produced in the second year of the contract, it reflects the performance issues which gave rise to concern over a period of many months. The strategy identifies that the focal areas will be as follow:

- **Internal communication:** Enable effective internal collaboration by keeping key stakeholders well informed and facilitating processes for them to communicate with each other

- **Multi-stakeholder engagement:** Support active participation and dialogue processes within and among multi-stakeholder groups involved in MeTA

- **National support:** Support national level communication plans

- **External engagement**: Share knowledge and engage external audiences

The strategy identifies a number of ways of achieving these objectives but not all are in

place. Annex 4 attempts to summarise current communication processes and channels and identifies current activities and performance against the draft strategy.

The internal communications focal area shows particular problems with

- A lack of clear communication of corporate and individual objectives
- The lack of internal team briefing processes
- Lack of performance management (i.e communication about what has/ has not been achieved and feedback)
- Inconsistent and unsystematised communication with TA

At national level secretariats lack basic communications hardware (email, dedicated telephone lines and photocopiers) and display considerable needs for capacity building in

- Report writing
- Advocacy and media relations
- Website design and support

In addition, there appears to have been little support to devise awareness raising campaigns or to agree how to create the infrastructure needed for effective disclosure

11.8 Website

The current website has won design awards and is well laid out. It incorporates links to country websites and also dedicated fora for learning, civil society discussion and general debate (known as D groups). In general these are poorly used and only by a minority of country level people. Between the period of 01 January 2009 to 31 January 2010 the MeTA site had received a total number of **9561** visits. (735 a month on average) The total number of pages visited was 45,899.

The website was commissioned before the current secretariat was appointed and needed a significant redesign with a more user friendly front end. It was originally intended that this would be a repository for information from all countries. This was unrealistic given the support/ budget available and the legal implications.

It is not clear who quality assures information on the website although it is understood that Healthlink had internal systems for material they generated themselves. The contradiction between the role of the IAG on the governance page and the aide memoire which appears on a subsequent page is a good example.

Whilst the website is the main focus of “internal” communication between countries, the Secretariat and IAG **there is also a need for a vehicle which has the potential to act as the public face of MeTA. This could be achieved by a further redesign of the website so that it opens at a general home page targeted primarily at people who are not currently involved in MeTA. This should identify:**

- **What MeTA is**
- **Who is involved**
- **What it hopes to achieve and why**
- **How it believes this can be done**

- **Progress to date**

It is essential that this is articulated as a compelling vision and is specific about the precise role MeTA can play and the hypotheses on which it is based. Links to case studies and illustrative events would be beneficial. It is understood that this has been repeatedly requested by DFID.

Some of the countries have developed their own websites. Whilst some of these contain excellent material (e.g. the Peru video), there are others which are not updated regularly. Again there are factual inconsistencies with the main website and it is not clear to whom they are targeted. The communication team could have provided more support but there is a general principle about country ownership and this leads to the belief that support should only be offered when a specific "pull" request is received from the country. However, if countries are not aware that support is available, they are unlikely to ask.

Key Findings

The communications function of the IMS has failed to facilitate a vision with ownership from all stakeholders and to deliver a communications strategy which would result in coherent, consistent messages both internally and externally.

There is still work to undertake both internally and externally to ensure that MeTA's principles, aims and methodologies are understood. MeTA is one player amongst many in the field of medicines worldwide and its particular and precise role needs to be articulated. It is essential that all members of the Alliance and the Secretariat have a common mutual understanding and agree key messages and are consistent in their use.

11.9 Technical Assistance

11.9.1 International TA

The IMS have offered in country support through Technical Assistants (TA) on a consultancy basis. Many of these consultants had previous engagement with either the MeTA design or predecessor initiatives. This ensured the continuation of institutional memory and was clearly sensible. The work of the TAs has been valued in countries where they have acted both as a resource of knowledge, a support in the use of tools but also as facilitators, particularly in respect of work planning. There do not seem to be consistent systems in place for agreeing inputs and measuring effectiveness however. They all bring considerable knowledge and experience and employing them on a part time basis (Typically 3-5 days a month) is very cost effective.

There appear to be some lessons which can be learnt from the experience however. Firstly it is important that administration relating to contracting is timely; good consultants are in demand and there is a risk of losing them if there is uncertainty about continuity of work (many of them have been working on six months contracts, sometimes renewed late). Secondly, whist there is a discussion forum available, direct communication systems are required to ensure that all TAs are aware of the wider MeTA picture, are not

placed in a position where they are reliant on third parties to hear of developments and also that they have the opportunity to interact together to share experiences, materials and good practice. It is important that international TAs reports are read and responded to in a timely way, particularly if they contain material which requires follow up. Whilst not all TAs appear to experience all of the above problems, there appears to be a lack of consistency which may relate to their employing institution (some report to be recruited through different partners in the consortium).

11.9.2 National TA

There has been the opportunity for countries to benefit from national consultants but not all have opted for this option. It is evident that, where they exist, national TAs have played a very strong part in both the creation of the councils, launch ceremonies and the creation of the workplans. There is a very real issue concerning their role and reporting lines however. Some anomalies have arisen including

- The reporting line (formal or informal) of the co-ordinators to the TA in both Jordan and Zambia
- The fundholding role of the former TA in Uganda (through the company of which he is a partner)

It is not always clear whether national consultants speak for International MeTA or are part of local MeTA nor to whom they are responsible. In some countries (notably Zambia) country level MeTA is substantially dependant on the input of the TA who has technical credibility and can engage at a high level. Inevitably, much institutional memory resides with the TA and this may not be available if they move on.

It is recommended that, should local TA continue to be utilised either in existing or new countries, there should be consideration given to their accountability, their reporting lines and the ownership of any documents and records they create. TA is a cost effective and flexible support mechanism but the dangers of over reliance need to be avoided.

Both national and international TAs have a wealth of institutional memory and it may be worth considering removing them from any future secretariat tendering exercise and stating that they are a pool available to the successor Secretariat so this can be retained.

Key Findings

TA has been used effectively both nationally and internationally although lines of communication and accountability have not all been clear. It will be important to retain institutional memory in MeTA 2.

12. Partner Support

12.1 The role of WHO

There have been a total of three MOUs between DFID and WHO, each based on a standard WHO model with a management fee being deducted by WHO headquarters. The contracts included £550k during the design and early implementation and £700k to support work in non African countries. This contract covered in country funding including the provision of technical support (NPO or equivalent) including the surveys in the four non African countries. In addition, there was funding to support the engagement of representatives of the Essential Medicines team and regional support. WHO was also prepared to utilise resources which had been provided by DFID for the Essential Medicines in Africa programme for the three African countries

In addition, there have been contractual arrangements which WHO has facilitated with third parties, particularly in respect of survey work. These have operated less satisfactorily as lines of responsibility and communication have not been sufficiently clear. This has resulted in some delays.

Input from WHO at MMB and IAG has been strong and consistent. The co-ordinator has also undertaken a number of joint missions and attended international events. He has attempted to ensure complementary working with other WHO initiatives.

Whilst there is strong and visible support from the Essential Medicines team and, in many countries, the NPOs (not all of whom are funded through MeTA) are extremely supportive, it is more difficult to identify how the totality of resources available to WHO have been used. The arrangement does not incorporate a conventional reporting mechanism although the Medicine Programme Coordinator provides an overview at each MMB meeting. **Countries, however, do not know what WHO resources are available to them and this would appear to lack transparency and accountability.**

This evaluation identifies that there is a large amount of activity being undertaken by WHO in the MeTA countries but it is not clear whether some of this would be happening anyway under other projects (particularly GGM) There is no doubt however that WHO's technical support is much valued in the countries where it is given and their potential ability to engage with key partners is invaluable.

It is understood that the funding would be used in part to fund NPOs in all non African countries where they had not previously been created through the DFID funded WHO/HAI initiative. In Jordan, an enthusiastic WHO employee has been appointed although only on a short term contract (at one stage renewed monthly) but there were long delays (18 months) recruiting the NPO appointed in Peru and this relationship has been far from easy. In Kyrgyzstan the regional WHO officer has been most supportive and WHO has also engaged a local consultant.

Table 4. Involvement of WHO by country

Country	NPO	Council member?	Additional staff provided through WHO	HQ visit (Dr Forte)
Ghana	Already in place	Yes		Aug 2009
Jordan	Technical Assistant appointed May 2009 (MeTA funded)	Yes..non voting seat. The WHO TA is not always the representative		Jan 2010
Kyrgyzstan	No	No	Consultant appointed Oct 2009	Nov 2009
Peru	Medicines advisor appointed Nov 2009	No (observer status only)		November 2009
Philippines	Medicines Advisor in place. MeTA funds pay for secretary and travel	Yes	Research assistant and website administrator	Nov 2009
Uganda	NPO already in post	Yes		No
Zambia	NPO already in post	Yes		June 2008

In Uganda the workplan identified some input from WHO in respect of quarterly monitoring. This would not have been from the designated MeTA funds and did not materialise but it is difficult locally to get an overview of what money is available and how it can be accessed.

Although there are telephone discussions scheduled between the WHO co-ordinator and the IMS Technical Director, there are perceptions that communication between the IMS and WHO are not wholly satisfactory. Examples were identified including when the Secretariat has made major changes (like designating a TA to take over responsibility for surveys) without adequate consultation.

WHO continues its commitment to MeTA and there is evidence of collaboration across programmes in some countries as well as technical support. There is a recognition that MeTA is a long term initiative and it requires both time and nurturing.

"Trust has brought us here, we have not lost any of it and we now need time to consolidate"
Hans Hogerzeil, Director, Essential Medicines and Pharmaceutical Policies, WHO

Key Findings

The support given to MeTA from WHO HQ has been valuable. Input at country level has been variable and the level of resources available through WHO is not transparent. The support of multilateral-funded staff/consultants in Uganda, Jordan and the Philippines has been particularly helpful. Survey work commissioned through WHO has suffered some delays.

12.2 The role of the World Bank (WB)

The World Bank was perceived as a valuable partner in MeTA particularly because of its interest and expertise relating to governance. It was recognised that this went beyond the health sector. The World Bank was involved by DFID who recognised both its immediate potential for disbursement together with the significant influence it could have on key stakeholders in the pilot phase and also future rollout. It is clear however that there is not a unanimity of opinion within the alliance about how MeTA should operate and also possibly on some of the basic underlying principles. This may be the result of changes in key personnel in both the WB and DFID. The WB centrally has divided the role with one person involved in the operational issues through MMB and a second who provides strategic advice through the IAG.

At the commencement of META, the World Bank entered the Alliance as a partner and received funding through an Externally Funded Output (EFO) This mechanism was used for the purposes of simplicity and speed. The EFO provided a sum of £920k over two years and identified that the Bank would support MeTA in the following ways:

- By local membership on National Stakeholder For a (NSF) and by providing specific support in country as identified by the NSF
- By membership of the IAG
- By membership of the MeTA Management Board.

It is interesting to note that the annex to the EFO refers to the MeTA Management Board as advisory which raises issues about the understanding at that time on the governance arrangements.

The WB has a member on the MMB and a different member on the IAG. The IAG representative is minuted as having offered assistance to country representatives in accessing funds.

The country level involvement in MeTA is through the local TTL. This works well where the TTL has an enthusiasm for the MeTA concept. However, this has not universally been the case and more than one TTL or local Health Advisor has not supported the pilot nor attended council meetings. **There appears to be a discord between the support given to MeTA from the centre and the commitment locally.**

There have been fairly substantial differences in financial inputs from the WB with three countries benefiting significantly more (Ghana, Jordan and the Philippines) than the others. This appears to be the result of complementarity with existing work in these

countries in relation to access to drugs for malaria and public sector supply chain strengthening. It may also be relevant that, in Jordan, the WB had previously been closely involved in pharmaceutical reform. Following an initial piece of work commissioned by DFID, WB has funded the UK National Institute of Clinical Excellence (NICE) to undertake work as well as provided training in international procurement. However, where relationships are less close it appears that problems have arisen, e.g. Kyrgyzstan have found it difficult to access the $60,000 which has nominally been allocated to them.

In Ghana, the **Food and Drugs Board** tests drugs at sentinel sites using Minilabs. This work is important because of the prevalence of sub-standard and counterfeit drugs in Ghana. Work on antibiotics is funded by MeTA via the World Bank who responded to a request for proposals. Although the final report is not yet available, this work appears to have led to the recall of some sub-standard drugs – a clear example of MeTA funds having an impact. The recall was covered in the press and was one of a number of incidents which have significantly raised public awareness of quality issues.

It is interesting that, during the evaluation, at least one country level WB officer has stated that they believe that MeTA locally provides them with opportunities in relation to governance and transparency and they intend closer involvement. This suggests lack of local liaison in the past but also provides an opportunity for the future.

The WB also funded the successful Harvard Flagship course on pharmaceutical policy hosted in Jordan. The course design had been initiated and funded by DFID and the WB were asked to use some of their funding to support this first delivery event.

HQ level representatives of the WB have expressed the views that:-

- There needs to be greater flexibility and that a multistakeholder forum involving public, private and civil society sectors need not be a pre-requisite for support
- That the principles underpinning MeTA might be better achieved using targeted project funding to support innovative ideas within existing structures
- That the current processes are too transaction heavy with undue administrative and reporting processes

Given that there are these different perceptions and that there is a strong option that the WB may hold a pivotal role in the future structure of MeTA, **it will be important to ensure that there is commonality of understanding about the future structure and focus for MeTA together with the underpinning principles.**

Key Findings

Whilst the level of commitment to MMB and IAG has been considerable, it would appear that the financial investment has resulted in a response which varies significantly across countries and has not been substantial.

13. Establishing the MeTA principle in pilot countries

13.1 Gaining Government Commitment

The Ministries of Health in all seven countries committed, in writing, to MeTA principles prior to the establishment of MeTA structures. Politicians and senior representatives of the Ministries of Health attended the MeTA launch in London and many country launches also had Ministerial presence (Ghana, Jordan).

Given that much information, together with the remit to change policy, largely sits in the public health bodies this commitment is essential. The public sector is wider than just the Ministries of Health and also encompasses national procurement agencies and drug regulatory authorities. In Jordan, the Chair of the MeTA council is also General Secretary of the High Health Council and in Peru the Chair is Vice Minister of Health. In Philippines the Chair is the former Minister of Health.

In Ghana, where there was a change of government in 2009, MeTA received considerable support from the previous administration but this has diminished with the incoming government. The Zambian Chair is also a Parliamentarian but of the party currently in opposition. His involvement with APNAC (African Parliamentary Network against Corruption) is seen as very significant however.

Disclosure of information by the private sector, civil society and others can be extremely influential even where a government is not wishing to be involved in such an initiative. However, to action the priority areas for change and to ensure that impact is being achieved, governments must not only commit to making single survey results or "snapshot" research available; there must be an understanding that **transparency means committing to a continuous flow of information, indefinitely**. This ideally means embedding this work into the relevant departments and ensuring that systems are in place to continue collecting timely, accurate information but also to recognising the verifying and account holding roles of CSOs. To commit to this, requires a real understanding of the costs involved and the government commitment.

13.2 Establishing the MeTA Councils

All the countries have established multi-stakeholder councils in country and this is a major achievement. In some countries, there had been no similar engagement before and it is inevitable that much of the business content of meetings focused on process issues until trust could be established but there are signs that more substantive progress is being made in at least five out of seven countries. Some councils are still spending a significant amount of time and effort debating council membership however.

Countries participate in MeTA only if there is commitment from the MOH. This sort of endorsement is of the greatest importance and countries which continue to have active

political sponsorship from senior government officials (such as Jordan and Peru) clearly have great potential. Not all councils have managed to maintain this close engagement and this potentially means they are sidelined or perceived as "belonging" to another sector (both Zambia and Kyrgyzstan are, in part, perceived as being CSO led initiatives).

The start up phase for MeTA has caused some problems in that it is necessary to have the council in place before the secretariat is appointed and likewise to have the secretariat established in order to draw up a workplan. This has involved much voluntary input from interested parties because they did not have administrative support to call on at crucial stages. In some cases national TA could provide valuable support.

13.3 Multi sectoral involvement

All seven countries have involvement from the public sector, private sector and CSOs. In some countries there appears to be dominance from a single sector (CSO sector in both Zambia and Kyrgyzstan) but, in general, most councils are getting regular attendance and input at meetings from all three sectors as shown in the table below.

The scoring in this table is an amalgam of number of members' actual attendance and an assessment of level of contribution. This is not an exact scoring system so it hides, for instance, that, in the Philippines, there are a number of public sector members but their contribution appears to be declining, that there are fewer CSOs but they are currently very active and that there is good representation and contribution from the private sector

Table 5 Sectoral involvement in MeTA councils by country

Country	Public Sector	Private Sector	CSO
Ghana	xx	xxx	xxx
Jordan	xxx	xxx	xx
Kyrgyzstan	xx	x	xxx
Peru	xxx	xx	xx
Philippines	xx	xx	xx
Uganda	xx	xxx	xx
Zambia	xx	x	xxx

Many councils have additional members covering academia, professional associations, the media etc. Most councils also have places for WHO and the WB although these are not universally taken up. This suggests less commitment at country level than at HQ.

In Ghana the Council has a strong presence from academia; the ownership is with them, more than with the public sector representatives.

In Peru there is both a main national council but also a smaller Executive board. There are pro's and con's of this arrangement.

- It provides frequent and high intensity, focussed input.
- It ensures frequent contact with the secretariat and provides support
- It has the capacity to undertake more detailed analysis

However, the existence of an Executive may:

- Cause resentment and a feeling that decisions are being made away from the main meeting
- Cause disengagement from those not involved.

13.3.1 Successes and Good Practice

The fact that all country councils are multi sectoral and have been established in such a relatively short time period is an achievement in itself. All councils are meeting regularly and there is constructive debate on potential activities. Some of the longer standing councils, notably the Philippines and Jordan, are spending an increasing proportion of their time on substantive matters relating to information and potential disclosure and what changes are needed to policy and behaviour to achieve MeTA goals of improved access. Some countries (e.g. Jordan) have an effective system of sub-committees which oversee much of the detailed technical work.

The Uganda council meets for lunch prior to its council meeting. This has proved to be an excellent and informal way for the sector representatives to get to know each other better, exchange information and views and widen their networks.

It is evident that, whilst the bigger council bring together stakeholders from a wider range of disciplines and experience, the smaller councils are probably able to operate more openly and frankly. There is good international evidence that large committees tend to be more bureaucratic and less effective **and it is therefore recommended that future MeTA councils are kept as small as is consistent with adequate representation and ideally not bigger than 12-15 people. Willing additional volunteers might be utilised on working groups (some of which have been established).**

13.3.2 Barriers, Difficulties and Lessons Learnt

In order to establish a new country level MeTA there is a need for an identified facilitator with access to some resources. In different countries this role has been undertaken respectively by a potential council member, WHO NPO or equivalent and by a consultant. **Consideration needs to be given to some small start up fund plus in country support for any future new MeTA countries and the briefing of the catalytic facilitator. It is essential that this person has a real in depth understanding of MeTA principles so there is no misunderstanding of what stakeholders are committing to. This may require the production of targeted communication material.**

The major barriers for effective engagement are historic distrust, often based on lack of understanding, and lack of time, given that key stakeholders have busy lives. Increasing contact, particularly informal contact when teams have travelled abroad, has helped build trust and understanding. **It may be appropriate to additionally consider recreating these conditions in a cost effective way off site but in country, using an external facilitator.**

Most councils meet on the premises of one of the major stakeholders. This immediately creates a situation of power dynamics. The Ugandan experience of using a room at a local hotel moves players from their normal places of work and removes the potential tensions of meeting on premises which are perceived as "owned" by one sector. The additional costs are small and the benefits considerable.

13.4 Governance arrangements

In all countries there has been (and continues to be) considerable debate about the constitutions/ internal rules/ MOUs under which the councils are operating and not all yet have comprehensive transparent governance frameworks in place. **It is very important that the MeTA councils are visibly in line with international standards of good governance and can demonstrate that they have written constitutions/ internal rules and conform with these. It is particularly important that lines of responsibility and accountability are defined and that members recognise their representational role (where appropriate) and their accountability to their constituency incorporating the duty to consult and feedback.**

In some instances, individuals have more than one role e.g. an official of the MOH who is on the council as a public sector member may also, in his/ her private life also own a retail pharmacy. **It is important that there is transparency and that members sign a declaration of interests.**

Councils do not all meet very often and there is sometimes a need to take decisions between meetings. This is important in order to ensure activities keep to time for example. However if individuals or groups of individuals (e.g. the Executive Group in Peru or the Chair and co -Chairs) are mandated to make decisions, then this should be subject to certain boundaries (financial limits for example) and these should be ratified in full council retrospectively. This delegation needs to be specified in writing.

Table 6. Council's compliance with international standards of governance, by country

	Gh	J	K	Pe	Ph	U	Z
Agreed written constitution. MOU	X	X	X*	X	X*	X*	X
Method for identifying new/ replacement members specified	X*		X*				X
Agreed method for selecting chair	X	X	X	X	X		X
Agreed term of office for chair	X	X	X	X^	X^	X	X
Agreed circulation of minutes		X	X	X	X	X	
Identified lines of responsibility for Secretariat	X*	X	X*	X*	X	X	X*
Agreed process for planning and budgeting (i.e. workplan finalised)	X	X	X	X	X	X	
Agreed financial authorisation processes	X	X	X	X	X	+	X +

Agreed financial reporting processes to council	**X**	**X**	**X**	**X**	**X**		**X**
Declaration of interest agreement	**X**	**X**	**X**				**X~**
MeTA a legal entity	**X**						

*needs review
+ no MeTA council members are signatories
^ Term of office agreed but already over run
~ not all members have signed

13.4.1 Barriers, difficulties and lessons learnt

A decision was made that the organisation of MeTA in country was a matter for local determination. This was understandable given that in one country (the Philippines) there was an existing structure already in operation and that the context was very different in each country. However, it has been evident that the process of agreeing a constitution and associated processes has been both time consuming and, at times, contentious. Many of the councils have ended up being very large with the consequent problems of increased formality, less individual input and inevitable absenting of members.

It is recommended that, while it would be inappropriate to be prescriptive, a model constitution document and a check list be offered to any additional countries on which to base their local arrangements. This would result in faster establishment and could build on lessons from the pilot countries. This should include at a minimum:

- **Headings of a constitution and some guidelines for each section**
- **Suggested constituencies for membership**
- **A suggested maximum size for the council**
- **Arrangements for declaration of conflicts of interest**
- **Model financial instructions**
- **A model for using an external fundholder**
- **Model job descriptions/ role descriptions for the Chair, co-ordinator and for members**

Whilst there may be some variation between countries it is important that the arrangements for fundholding and the responsibilities for managing resources are in accordance with best international practice and are subject to periodic audit.

The IMS employed a financial consultant to provide some guidance (he was present at the December 09 country sharing meeting) and to undertake country "audit" visits scheduled for spring 2010.

13.5 Operation of the Councils

All of the councils are now in operation although Kyrgyzstan and Zambia were not established until July 2009 and were therefore later finalising their workplans. A great deal of council time in the initial stages has been taken up with process issues and this may be inevitable. All councils have active involvement of all three sectors.

MeTA has basic constituent principles which have been agreed in advance in a letter of commitment from the respective country MOH. Despite this there is a considerable difference in people's perceptions of the aims of MeTA. MeTA aims to focus on price, quality, availability and promotion of medicines and to achieve change by bringing information into the public arena. A study of council meetings and workplans suggests that many councils have been tempted into widening out their remit and interviews suggest that some members have a somewhat superficial view of what MeTA hopes to achieve and how they believe this will be achieved. The following are some of the answers given by council members from various countries to the question "What is MeTA there to do?" and demonstrate a lack of common purpose which should have been identified by the IMS and supported by communications material

"MeTA will bring out corrupt officials"
"MeTA is a good mechanism for learning exchange"
"It is to do with systems effectiveness"
"MeTA will make us work in harmony"

It is noticeable that those councils who have more access to technical support either through TA, WHO or through partner organisations, have been able to undertake more detailed discussions on strategic issues such as situational analysis, information identification, disclosure, survey findings etc. Not all the councils have the benefit of good supporting background research and analysis which means that they are less able to make decisions. It is noticeable how some countries have repeatedly considered "draft" survey reports due to lack of capacity to quality assure and finalise these before disclosure. In countries where partners who themselves have this sort of capacity are prepared to input resources "in kind", access to researchers, data analysts and academics has been very valuable. There is an issue however about partners also being implementers as it is more difficult for them to be held accountable. If the work is done "pro bono" or on a secondment then peers find it difficult to hold partners to deadlines and quality standards. Likewise if this work is "contracted" and paid for from MeTA resources under the workplan there is the potential for issues of probity and transparency.

13.6 Evidence of private sector and civil society involvement

All councils have multi stakeholder involvement although the input varies between countries. Two countries in particular have an imbalance at council level. Kyrgyzstan has a comparatively new private sector which is dispersed and understandably this sector is not well represented nor does it have a strong voice which can speak across the private sector. However, the Krygyzstan MeTA initiative is strongly owned by civil society.

In Jordan the CSO sector is relatively poorly developed. The aim in all countries has been to create a CSO co-ordinating body but, whilst these have been created, they do not all have many members. In Jordan, civil society is represented at council level by an established Consumer Organisation and a rotation of "Patients and Friends" groups which are basically disease based support groups. These groups are not at all

experienced with Councils such as MeTA's and, indeed, it is not always clear what the incentives of membership are for narrowly constituted patients' groups.

Zambia is another MeTA council dominated by civil society interests. A decision was made by the council to locate in the offices of Transparency International but this may not be helpful in the long term.

The benefits of engagement between the three sectors are becoming visible, however

Uganda can demonstrate a significant success in civil society and private sector engagement. For the first time, representatives of both sectors were fully involved in the MOH strategic planning process for pharmaceuticals in 2009 and were able to present relevant material
Peruvian regulations were amended specifically in early 2010 in response to a request from a private sector MeTA council member, made in a MeTA meeting – announcement was made in minutes of Feb 26 2010 council meeting.

Key Findings

All seven MeTA pilot countries have now established multi-stakeholder groups (Councils) and have agreed workplans which include proposals to generate and disclose information relating to price, quality, availability and promotion of medicines. This is, in itself, a major success Not all Councils have equal involvement from all three sectors but there is regular multi sectoral attendance. Governance frameworks vary and not all yet wholly conform with international best practice.

Whilst much time was taken initially on process issues, there is now evidence that the longer standing councils are utilising an increasing proportion of their time on substantive issues relating to access to medicines.

14. National MeTA Secretariats

Each of the MeTA councils is supported by an established secretariat. These organisations vary considerably in size and capacity. In some cases additional resources have been obtained to fund posts and in others MeTA partners have seconded staff on either a full or part time basis.

Table 7. Staffing, location and TA support provided by country secretariats

Country	Number of Staff	Location	Local TA support
Ghana	Co-ordinator – f/t Senior Technical Adviser 0.2 wte Data analyst 0.5wte Accounts officer- f/t Office managerF/t	Own premises	0
Jordan	1 co-ordinator 1 Admin Asst P/t accountant	High Health Council (govt)	1
Kyrgyzstan	2 x 0.5wte	Own premises. Co-located with fundholder.	2 part time
Peru	1 full time 3 part time	CIES (CSO)	I (actually international but locally based)
Philippines	1 f/t Executive Director 1 f/t co-ordinator 2 f/t researchers 1 f/t website administrator	University but moving to WHO in DOH compound	0
Uganda	1 f/t co-ordinator 3 attached 0.1 wte	National Drug Authority	0 (1 until Sept 2009)
Zambia	I f/t co-ordinator 1 f/t administrator (intern)	Transparency International Zambia	1

The roles of the secretariat vary in different countries and the competences (knowledge skills, attitudes and behaviours) required are wide ranging. A simple competence framework is appended at Annex 5 which demonstrates the range of core skills and knowledge required by the Secretariat (which may be a single co-ordinator) **If MeTA is extended to a second phase and countries are added, it is suggested that some form of development centre (i.e. to identify current available competences and offer personal development / training to acquire the basic minimum) is offered. In addition guidelines on basic systems and standard pro forma documentation might be offered as part of a secretariat toolkit or in a video-link series of**

workshops.

Secretariats also vary where they are located and to what basic accommodation they have access. The locations were chosen by the councils. It is important to recognise that the location of the secretariat gives powerful signals about its loyalties and ownership and this may be a lesson for the future. **Whilst co-location with a partner organisation may make economic sense, it is important to ensure that MeTA is visibly "owned" by a multi sectoral alliance.** Currently the location of Zambia MeTA appears to potentially compromise its independence. The solution arrived at in the Philippines appears to be positive where the secretariat will shortly be housed in WHO. It is believed that this will encourage greater engagement with the MOH. Likewise, there are many advantages in MeTA being located in the High Health Council in Jordan though the office manages to retain a distinctive identity with clear MeTA branding.

In order to work effectively and efficiently all secretariats need adequate space to hold a small meeting, computer access and support (back up/ computer security etc), a dedicated filing capacity, photocopying and printing, a dedicated telephone preferably with an answering function and internet access. This is not currently available to all secretariats.

Whilst some secretariat staff are seconded, the majority have been recruited on short or fixed term contracts. Consideration needs to be given to their career progression and the likelihood of long term retention. Whilst no particular problems were identified in terms of salary levels or conditions of service, consideration needs to be given to medical insurance cover for secretariat staff travelling overseas. Many council members reported having cover from their employers but this did not apply to co-ordinators.

The degree of delegation to secretariats appears largely driven by the chairs/ co-chairs of councils. In some cases the degree of autonomy given to the co-ordinator is probably too small for effective operation. This is the case where the councils or executive groups are relatively "hands on" as in Peru but also where the capacity of secretariats is limited and they are perceived as largely administrative support bodies without the role of performance managing the workplan (e.g. Uganda) **It is of the utmost importance that there is agreement about what decisions the co-ordinator can make without recourse to council, what financial authority they have and to what extent they can action decisions once overall approval has been given**. Lines of accountability are not always clear and confirmed in contracts/ job descriptions.

The relationship between the co-ordinator and local consultant appears to need greater clarification in both Jordan and Zambia.

14.1 Successes and Good Practice

Secretariats in the Philippines and Ghana have in house research/ data analysis capability. This will be increasingly important as information becomes available and there is a need to synthesise.

14.2 Barriers, difficulties and lessons learnt

Whilst all secretariats are working hard and supporting the councils, some currently have inadequate capacity and facilities. If MeTA is to move into activities, including disclosure and advocating/ influencing policy change, then the Secretariats will need to have more than an administrative capability and will need to build increased communication and dissemination capacity.

If new countries adopt the MeTA principles and create secretariats, it is suggested that the following points be considered:

- **Optimum location for working collaboratively with complementary initiatives without compromising independence**
- **Need for basic minimum facilities and services**
- **Need to ensure that secretariat staff have range of essential competences/ and or can develop these with appropriate support**
- **Need to agree limits of delegation and authority**

Key Findings

In country secretariats vary in size, location and capacity. There is a need to identify what competences are required and to design the secretariats accordingly. Location in WHO (Philippines) or a sector partner premises may, in some cases have significant advantages, (e.g. Jordan) but in others (e.g. Zambia) may compromise independence.

15. Building capacity in country

15.1 Technical Support

Countries have benefited from a number of support/ capacity building activities. All MeTA countries have been able to request a dedicated international Technical Assistant who has worked with them. Some TAs were involved in the initial scoping exercises and transferred over once the MeTA contract was awarded. These consultants have varied backgrounds but they have been able to support the establishment of councils, the workplanning process and the application of MeTA tools including the baseline surveys.

In general, the international TAs are not based locally and therefore support is via email and Skype and through visits. The consultants vary in their time commitment but there is a perception that they may be underused. This is a consequence of the "pull" model and seems to arise because countries may not be aware of exactly what is available both in terms of time and competences but also of the limited budget for to enable country level working. Information about what resources are available should have been addressed by the IMS in country visits and workplanning.

Many of the consultants were involved with countries during the scoping and design phase. There has clearly been an advantage to the continuity of approach and **it is strongly recommended that, should MeTA 2 take place, the consultants should not form part of the tender process but be available to any future secretariat.** Whether they continue to be used will, of course be driven by the wishes of the countries, the consultants themselves and the successful bidder but there is a significant benefit in retaining institutional memory and retaining relationships of trust as has been demonstrated in the pilot.

Some countries have also used national TA. It is not clear to what extent these have benefited from support from the international secretariat although some have had the opportunity to attend international meetings.

There are some issues relating to the relationship between all of the TAs and the Secretariat and between the TAs themselves. Any future arrangements should ensure that:-

- TAs are able to allocate time knowing their contractual position well in advance
- TAs should be clear about what is expected of them and how they will receive feedback
- TAs should receive regular briefings from the Secretariat to ensure that they are aware of international level activities and thinking as well as specific issues relating to the country they work with
- TAs should have a regular opportunity to exchange information and learning in addition to the dedicated electronic forum (which is currently not extensively used).
- There should be clarity about the reporting mechanisms for TAs and the status of their reports. This should include issues of transparency but also the

expected actions to be undertaken in the instance of concerns over probity.

In recent months, two international TAs have taken on a project wide role in relation to CSOs and baseline. Their roles take over responsibilities previously held by other partners. It is important to be aware of the sensitivities of this as communication from the IMS has been perceived as inadequate in respect of these changes and it has also caused a degree of uncertainty of role and status at country level.

15.2. International learning events

MeTA has organised a number of events which bring together country participants from all sectors and national co-ordinators. These include;

- May 2008 MeTA Launch
- May 2009 Events accompanying World Health Assembly
- May 2009 Events accompanying Global Health Council
- Sept 2009 Strategic Planning event
- Dec 2009 Country sharing event
- Jan 2010 Jordan courses

There is a clear perception that these have achieved a number of benefits including

- Changes in attitude between stakeholders from different sectors, particularly with more cross sector contact
- Cross country learning and exchange
- Team building amongst the participants from each country as they work together and increase trust in each other
- Increased competence through the acquisition of knowledge and skills (particularly skills related to the use of tools for analysis and achieving change)

Bringing together participants from seven countries is inevitably expensive and MeTA has attempted to “double up” to reduce costs. Thus two courses were run back to back in Jordan. The first was the Harvard Flagship Pharmaceuticals course and the second was a Multi Stakeholder Participation course run by facilitators from Wageningen University, Holland. This had benefits in reducing travel but may have resulted in the second course being less able to engage participants who were tired and anticipating returning home.

It is worth considering the optimum size for learning events. The two courses run in Jordan each had approximately seventy participants plus observers. The Harvard team were very experienced, their materials had been extensively tested and the facilitators demonstrated an excellent grasp of the challenges facing participants. They managed to keep all participants actively engaged and the process controlled and productive. This course was widely acclaimed as extremely effective.

The Multi Stakeholder Participation Course was arranged at short notice. It’s aims were to help people understand the barriers to effective MSH working and to develop

strategies to overcome these. The team from Wageningen had been explicit that they normally only worked with groups of up to 25-30 maximum and had agreed, reluctantly, to increase this to forty (actually 70+). The course material was derived from a similar intervention in the agricultural sector which normally lasted in excess of five days. Little contextualisation had been undertaken and briefing by the IMS was clearly inadequate. The exercises undertaken were not suitable for such large numbers and the presentations were overly detailed and not always relevant. The IMS recognised this, however, and were very open with participants in acknowledging their part in the problem. This was appreciated by participants who saw it as evidence of the openness and trust inherent in the MeTA process.

Interactive teaching is essential, yet many participants are more used to a more didactic style. Some participants found it difficult to work informally and some of the participatory exercises were perceived as somewhat counter culture. It was noticeable that some teams were much more comfortable with exercises involving personal disclosure than others. **It is important that course leaders are very aware of cultural and religious differences not only in formal inputs but also in informal dialogue and asides.**

At each of the three international learning and sharing events observed by the evaluator there were a number of MeTA secretariat staff, together with members of the MMB and observers. This inevitably has the potential to change the dynamics. At some stages the non country attendees acted as participants and at others they observed. Their influence could be clearly seen and, on some occasions, this was facilitative. It would seem important however to be very clear with “observers” exactly what is expected of them and, if necessary, to use them as non contributing rapporteurs or as facilitators or indeed to ask them to withdraw as appropriate.

Where courses are being prepared by external bodies **it is of the utmost importance that there is consistency of core message, that there is liaison to avoid duplication of either materials or exercises and that the content complements work being undertaken by the Secretariat and TA.** Whilst the Harvard material were extensively tested by the Technical Director and others, there was no liaison between the two course organisers nor discussion with TAs or other capacity building delivery agents (particularly WHO which did not appear to have had the opportunity to input to conceptual discussions).

The Harvard Flagship Pharmaceutical Course

The course was adapted from the International Flagship course and built on a previous event delivered in 2008 primarily for DFID staff. The course was based on providing participants with both knowledge and techniques to achieve reform in pharmaceutical policies and encouraging them to share experience and learn together. The course was clearly well received by participants but the benefits appear to have wider applications than the immediate course objectives.

- The course built on the existing, tested, well regarded Flagship Course and was able to use/ modify existing course materials. (cost effective)
- The course materials developed for MeTA are felt to enhance the generic Flagship courses in the future(cost effective, enhancing understanding of

pharmaceutical challenges in future attendees/ health professionals).
- The specific Pharmaceutical Flagship Course can now potentially be used in the future both as part of MeTA (Phase 2) but also for other initiatives related to pharmaceuticals in other countries or internationally (cost effective, creating new resource)
- The course provided enhanced cross country learning and understanding. It strengthened the concept of multi sectoral engagement
- It also acted as a team building exercise for country teams (working on "neutral" case studies was perceived as less threatening and discussion on the general allowed parallels to be made with the particular)

15.3 South South Learning

A number of MeTA council members identified the desirability of south;south learning. To some extent this has taken place through the country sharing meeting in London and also on the Jordan courses. In addition there are email discussion sites available but these are not well used. **One of the problems is the lack of a common language for informal or self generated learning**.

The idea of inter-country visits was floated on the last day of the Jordan course. In early February (8th), the IMS circulated a proposal form whereby countries were invited to put forward details of visits they would like to make to other MeTA pilot countries.

It is not clear where this initiative originated and it does not appear in the mid year re-planning paper in November 2009 nor in MMB minutes prior to the Jordan meeting in January. It might be argued that this is an example of flexibility and responsiveness on discovering available funds but it gives rise to a suspicion that it was an effort to increase disbursement. This impression is strengthened by the stipulation that visits had to be made before the end of March. The criteria were fairly specific in that teams of four from particular sectors were required and the aims of the visit had to be articulated. Proposals had to be submitted by the 20th February (i.e. within ten working days). **As a south south learning activity this proposal may have had merit but to attempt to action it at such short notice was unrealistic and it seemed highly likely that any visits which resulted were unlikely to be well prepared, to involve the people who would most benefit and therefore to be value for money.**

15.4. Activities to build capacity of civil society participants

Over the past two decades concepts of the non-governmental sector have changed significantly. The influence of good governance initiatives means that NGOs, faith based organisations (FBOs) and community based organisations (CBOs) are now seen as part of civil society, with important roles to play in social accountability, advocacy and promotion of citizen's rights, as well as in service delivery. In some countries this concept is well established but in others the concept is relatively new.

In Ghana, Zambia and Uganda there have been a number of organisations who would

wish to be involved but Jordan and Kyrgyzstan do not have a tradition of civil society. In these countries civil society organisations are largely disease focussed.

A "Spin Off" Benefit of MeTA
The **mapping of civil society organisations** in Jordan resulted in the first-ever list of functioning patients'/friends' groups. These groups have in the past operated separately, and with little understanding of many of the policy issues related to medicines. The mapping exercise involved some ingenious detective work – based on an out-of-date list of contacts, the consultant journeyed to rich and poor parts of Jordan, private houses and workplaces to meet patient group representatives.

CSOs had earmarked and separate funds in country and benefited from specific capacity building activities. In some countries this has caused some tensions and these appear to have arisen because of less than clear communication at start up. Chairs of some country councils expressed concern that MeTA branded activities may be taking place without discussion at Council and without ensuring complementarity and consistency

A number of events were organised in country and regionally to build capacity in CSO participants. There was a recognition that in some countries the CSO sector was very limited (e.g. Jordan) and in others there were a large number of small specialist CSOs who had relatively low levels of resources including full time employees. There was a conscious decision made to encourage existing CSOs to form collaborations in order to participate effectively in MeTA. This has been achieved in Philippines and Uganda led by Health Watch and HEPS respectively. Each country was given a ringfenced fund for CSO capacity development but it has taken a long time for the workplans associated with these allocations to be signed off and thus release funds.

It was possible for countries to seek an advance on these funds for planning purposes but the paperwork involved in one country to achieve a release of £5500 seemed excessive and unlikely to motivate CSOs (a 35 page MOU to be signed by both the IMS and the coalition lead organisation) **Whilst it is important to achieve probity with publicly sourced funds, it is desirable to adapt processes so they are in scale with the size of the sum involved.**

Country Budget/ spend	CSO Planned Activity	Achievements
Ghana	Networking; Capacity-building;	20 organisations recruited at national and regional level Two workshops on transparency and access to medicines, stakeholder engagement and advocacy skills

	Increasing consumer access to information.Production of poster	FM radio to convey activities of CSO with MeTA
Jordan	Workplan agreed but not yet implemented Meetings held and informal capacity building. Formal training planned	First time to bring together disparate patients' groups – momentum created for them to continue collaborating.
Kyrgyzstan	Three different versions of workplans have been agreed over time. Mainly seed funding for small surveys by CSOs and capacity building on joint issues of interest.	CSO Forum planned for 13-14 April 2010 (and MeTA KG Forum 17-18 April)
Peru	Workplan submitted Dec 2009 • CSOs receive training on access to essential medicine issues • 2. Agree priorities for advocacy	CSO forum held Nov 2009 Identified CSO co-ordination organization (FOROSALUD)
Philippines	Policy analysis and development Advocacy and campaign strategies Information and advocacy (brochure/ newsletter/ fact sheets) Capacity building workshops CSO webpage on Ph MeTA website	CSO mapping conference with 60 stakeholders 24 organisations formed coalition (CHAT) with 5 work groups Fora on Access to Information and Drug Pricing (July)
Uganda	Develop CSO MeTA educational & Promotional Materials National MeTA CSO capacity building workshop Develop CSO positions on low availability and high stock out of medicines CSO mobilisation, Coordination and Communication Monitoring and Evaluation	Workshop report printed and circulated 50 attendees, 25 organisations. Fact sheets and briefing material developed. 2 press statements, media articles Coalition of 5 organisations established Not yet started
Zambia	Workplan agreed Nov 2009 covering: • CSO mobilisation, collaboration and coordination	Coordination meetings established, Convened a successful

	• Policy dialogue • Training in: advocacy; supply chain management; budget tracking; research skills; government structures and procedures; intellectual property rights and TRIPS agreements • Recruitment of a CSO Coordinator and interns.	skills building workshop Coalition Coordinator identified

Key Findings

A significant proportion of the META budget is spent on capacity building activities. Support to countries has been provided through international and national Technical Assistants (TA); in general, this has worked well.

A number of regional and international courses have been held. In general, these have been well received and fulfilled a dual role in increasing skills and knowledge but also increasing trust and engagement. Participants also value lesson learning from other countries and solidarity created when comparing successes/challenges. The Harvard Flagship course was particularly successful although ideally it should have been available earlier in the MeTA establishment process.

The optimum size for learning events needs forethought and it is important that delivery agencies ensure complementarity and consistency of message. The desirability for south: south learning has been articulated but lack of a common language is inhibiting.

16. Workplanning

16.1 Overall progress in design

Most countries now have agreed workplans but the process has been lengthy and difficult. The Ghana country report provides details of how it took over a year to produce a final workplan and the Peru workplan is not yet fully finalised after nearly two years. There is a perception that the creation of these workplans could have been undertaken much more quickly with more timely support from the IMS although, in some cases, help was offered but refused. This was particularly the case in Zambia where, late in the process, the need for a logframe was identified but the competences to develop one were not available locally.

A clear message was received in some countries that workplans should aim for "low hanging fruit" (an idea which, incidentally, was found offensive by one members of MeTA Peru who felt that it was important to aim high to galvanise people). Whilst the need for demonstrable quick wins is understandable, this has resulted in MeTA being an alternative funding stream for existing activities in Uganda, as outlined in the country annex (and possibly other countries).

Some workplans are very comprehensive (the Ghana one details 24 activities and Peru has 34) and, during a pilot phase, some of the activities may be unrealistically ambitious. Several country workplans identify the need to leverage resources from other funders (mainly DPs). Whilst this was probably realistic in the Philippines where the EC is already supporting MeTA, there may not have been the capacity to make this happen in other countries in the time available.

Workplans have gone through several iterations and all countries were asked to reprioritise in October 2009. The original Peru workplan was developed in 2008 and the most recent was approved in February 2010. The reason for these iterations tends to be the changing local environment including changes in key stakeholders (including political change) economic developments (changes in tax regimes affecting local industry for example) and changes in legislation. In addition, as councils mature, they may become more realistic about what can be achieved and more sophisticated in their costing and planning processes.

16.2 Overall progress in delivery

Delivery in terms of both completion of agreed activities and disbursement is relatively slow in most countries. The countries which have had MeTA established longest and which have most capacity, are inevitably performing best. There does, however, appear to be a degree of acceleration now that the process issues relating to the creation of councils and the discussions on workplans have virtually finished.

Many countries have relied too heavily on internal capacity to undertake activities. In some cases this is due to a shortage of local TA capacity. For example the USAID funded SURE programme in Uganda ($39m over 5 years) has inevitably affected the

availability of local consultants.

Whilst financial disbursement does not equate to achievement of workplan objectives, the following table is telling. With the exception of Ghana and Philippines, the countries below are showing spend against a workplan which was covered by an MOU running up to March 2010. Ghana and the Philippines have received additional resource and their MOU now runs to September 2010. Countries are currently reviewing their workplans with an expectation of additional resource and there is a real question whether this is realistic given performance so far.

Table 8. Expenditure against budget by country

Country	Budget	Total Disbursed to country level	In country spend	Date of report	% of total budget	% of funds received at country level
Ghana	£200,000	£150,137	£97,362	15-Feb-10	49%	65%
Jordan	£125,000	£125,000	£63,167	31-Jan-10	51%	51%
Kyrgyzstan	£100,000	£100,000	£33,037	31-Dec-09	33%	33%
Philippines	£200,000	£150,000	£77,425	15-Feb-10	39%	52%
Uganda	£100,000	£100,000	£34,106	28-Feb-10	34%	34%
Zambia	£100,000	£100,000	£29,623	31-Dec-09	30%	30%
Peru	£100,000	£100,000	£17,882	31-Dec-09	18%	18%
	£925,000	**£825,137**	**£352,602**		**38%**	**43%**

Source IMS report MMB March 2010

16.3 Suggestions for changes modifications

Work planning has taken in excess of a year in many countries. In future this process needs to be accelerated. This can potentially be achieved in three ways

- Simplifying the associated paperwork and focus on a smaller number of realistic activities
- Providing specialist TA to facilitate the process and support costing and logframe development
- Providing a more structured framework of activities which might be undertaken under MeTA

A greater use of local TA in country to deliver the workplan must seriously be considered by councils, recognising the constraints placed on council members and the capacity of secretariats. This has resulted in slow delivery and thus absorption. In addition, there needs to be tighter performance management of activities in some countries with payments from the councils linked to the achievement of milestones and timelines.

Key Findings

Workplanning has been relatively slow and the rate of spend has thus been low. A

greater use of local TA in country might have facilitated the process, There needs to be tighter performance management of activities in some countries with payments from the councils linked to the achievement of milestones and timelines.

A message was received in some countries that workplans should aim for "low hanging fruit" Whilst the need for demonstrable quick wins is understandable, this has resulted in MeTA being an alternative funding stream for existing activities in Uganda (and possibly other countries).e.g. the evaluation of the Uganda Pharmaceutical Procurement Plan which is a routine annual exercise

17 Harmonisation in countries

Annex 2 identifies the plethora of initiatives being undertaken worldwide in respect of access to medicines. Many of the MeTA countries have multiple inputs both from external support but also managed by the MOH and other key players. Some initiatives in particular have considerable similarities to MeTA and there appears a need for greater dialogue on comparative advantage. There is some indication of successful joint working between MeTA and GGM in the Philippines and Jordan.

MeTA is unusual for a DFID funded programme in that it has been set up across a number of countries and outside normal country planning processes. There is a real issue about whether MeTA complies with Paris Principles given that not all workplan activities appear to be reflected in MOH planning processes. Only in Peru has there been a demonstrable link around broader policy processes.

MeTA has relatively high transaction costs and, as yet, it is not possible to demonstrate that these are outweighed by unique benefits. Whilst the question was not asked of all MOHs, there is an issue as to whether greater impact could be achieved for the investment through other existing initiatives and support mechanisms. However it is recognised that none of the complementary initiatives involves the unique MeTA multi sectoral involvement framework.

All MOHs have written a letter of commitment expressing a wish to be involved in the initiative and committing to MeTA principles. However, in Ghana, Kyrgyzstan and Uganda, there is commitment by development partners to a harmonised approach under a SWAp in line with Paris principles with support to the national planning process. In Zambia there is a commitment to budgetary support.

The presence of the Ministry of Health or equivalent on all MeTA councils should ensure that duplication with other similar initiatives is avoided but it is evident that there are some perceived overlaps.

In Jordan where the chair of MeTA is Secretary to the High Health Council , they have recently published the National Health Accounts A major conclusion of the NHA as a whole has been. "*An effective strategy of cost containment, to include greater use of utilization review mechanisms and the implementation of an effective prescription drug policy, should be of highest priority*" This indicates that the issue of rational use of

medicines has achieved high profile.

There does not yet appear to be good liaison/ communication with country co-ordination mechanisms (i.e Development Partner fora) This could be better achieved with support from DFID staff in country or through WHO or the WB.

As yet there is limited evidence that any of the MeTA councils are engaged with other initiatives related to governance or transparency in their countries although Philippines and Jordan are working with GGM and Zambia is housed in Transparency international offices.

Key Findings

MeTA is unusual for a DFID funded programme in that it has been set up across a number of countries and outside normal country planning processes. There is a real issue about whether MeTA complies with Paris Principles given that not all workplan activities appear to be reflected in MOH planning processes.

MeTA has relatively high transaction costs and, as yet, it is not possible to demonstrate that these are outweighed by unique benefits. Whilst the question was not asked of all MOHs, there is an issue as to whether greater impact could be achieved for the investment through other existing initiatives and support mechanisms. However it is recognised that none of the complementary initiatives involves the unique MeTA multi sectoral involvement framework.

18. Progress towards data identification

The collection, analysis and disclosure of robust data previously unavailable in the public domain together with the multi-stakeholder process is a key purpose level objective of MeTA. The MeTA principles are based on the hypothesis that, through multi-sector engagement, key stakeholders will be more prepared to share information concerning price, quality, availability and promotion and will see the mutual benefit of doing so. There are clearly both barriers and drivers to this hypothesis and particularly the private sector and the public sector may have circumstances where they are reluctant to bring information into the public domain.

In the case of the public sector this could include:-

- There is no political support for making information public
- There is a risk that information might show the sector or politicians in a poor light
- That information is poor quality and subject to (embarrassing) challenge
- That there is no clarity about who can release the information
- That the possession of information is perceived to confer power

Likewise the different sections of the private sector might not wish to reveal data concerning

- Their market share
- Their margins/ mark up
- Their pricing strategy

However the incentives and bottlenecks vary for different players in the private sector supply chain and it is possible to identify real advantages in sharing above the desire to be seen as a socially responsible organisation including

- A greater understanding of demand/ health trends
- Obtaining a better picture of the local market environment
- Contributing to the improvement of supply chain efficiency which will enable the private sector to reduce storage capacity and distribution costs
- A better understanding by the public of issues relating to generics/ identification of counterfeits/ rational use of medicines
- Public understanding of the codes of ethics/ promotion applied internally and internally in the private sector
- A place at the table for policy discussions

However, whilst individual members of the private sector (e.g. manufacturers) may want this information for themselves, they may perceive that it loses value if all their competitors also receive it. Thus the incentive for involvement is less.

One of the notable features is that many councils (although not all, e.g Ghana and Jordan) have identified price (and thus markup) through the supply chain as the key

information to obtain, yet this may be one of the more difficult to achieve given the sensitivities involved. Even where price is partially the result of government policy (e.g. Jordan) it may not be possible to achieve change given the other interests involved. Given that MeTA is designed to focus on four aspects (quality, price, promotion and access) there may be greater mutual benefit in also identifying key information which is indicative of these aspects first to establish trust (e.g. information to users about how to recognise counterfeits and which good quality medicines are registered in country). However, it is important not to allow any party to back out once they have achieved some benefits and to absent themselves from the more difficult and controversial issues. This should be achieved through a quid pro quo negotiation.

There are real drivers towards disclosure for all sectors and there is evidence within the MeTA countries that these are being recognised. All countries are participating in the identification of baseline data but not all councils are using this information to support future workplanning and prioritisation. The data is collected by survey and the surveys are standardised in all countries. There are three components to the baseline:

18.1 Component 1

18.1.1 Disclosure Survey

This methodology has been developed by the Department of Population Medicine at Harvard who are also the Collaborating Centre in Pharmaceutical Policy for WHO. It aims to provide a coherent, referencable body of data showing what is available in countries, where it resides and how accessible it is. All seven countries have now undertaken this exercise but it appears that there are variations in quality and completeness. Councils and secretariats were encouraged to complete this survey themselves but it is felt to have been viewed as an onerous body of work. It appears that the benefits of using it as a multi-sectoral group, working together to identify the present situation and to set priorities, were not fully understood by all countries. In Jordan, the council sat together to complete the exercise and described it as eye-opening. By looking together at websites, some practical issues of data availability became apparent. Sometimes data was available, but was difficult to find on a website; the practical difference between “disclosure” and “accessible to the individual citizen” became apparent.

In Peru, the task was outsourced to a consultant and it appears that they changed the methodology/ format which makes comparisons more difficult. Also in Peru, this exercise caused a degree of resentment as there was a feeling that it was not country driven and was “imposed upon them”. **It is clearly very important that communication on exercises of this sort is excellent and misunderstandings are avoided.**

18.1.2 Pharma Sector Scan

This has been undertaken initially only in Ghana and the Philippines and will be rolled out further once the tool has been verified. It aims to assemble existing country level data, assess its validity, compare it, where possible, with data from other countries and/or external standards, and assemble the data into a structured format useful for country priority setting. The survey is carried out by local consultants and there were

some delays in finding appropriate people to undertake the work locally in the Philippines. This may be a constraint in other countries where local consultants with an understanding of the sector and survey methodologies may be scarce.

18.2 Component 2

18.2.1 Health Facility and Household Surveys

These surveys provide an indication of the degree of community access to essential medicines through healthcare facility and household surveys and build on work already being undertaken by WHO.This meant that Uganda had already collected this information before MeTA was established and this was recognised at design phase. The process is expensive and resources were not available to undertake the survey in all countries. Ghana has completed the survey and Harvard are currently supporting validation. The next stage is for the Ministry of Health to officially launch the survey findings. With the support of a locally contracted consultant, Philippines has completed with the exception of two regions. In Jordan, the survey findings are due to be comprehensively discussed at a workshop shortly after the time of this evaluation.

Maximising Resources for Surveys
Drug **pricing surveys** are important in Jordan because of the very high prices of medicines bought over-the counter. A pricing survey was added on to existing plans for household and facility surveys. This is an example of making more of an existing opportunity – it was cheaper to combine the surveys than to conduct a separate stand-alone pricing study.

18.3 Component 3

18.3.1 Multi-Sectoral Stakeholder Involvement

This survey is based on the Rapid Agricultural Appraisal Knowledge (RAAKS) methodology developed by Wageningen University. The objective of the Multi-Stakeholder Assessment is to provide an indication of the quality of the multi-stakeholder process, which includes a 360-degree assessment of the existing levels of engagement

The Institute of Development Studies, University of Sussex were contracted through WHO to undertake this work, initially in the Philippines and Uganda. The work appears to have been delayed due, in part, to contractual delays. The work in country is undertaken by national consultants and there was a transparent process (public advertisements/ standardised interviews) used for selection.

A formal letter of invitation/ authorisation was issued in the Philippines and the survey has started with a presentation to MeTA council followed by individual interviews. Progress is a little slower in Uganda but both surveys are due to be completed by April.

At the time of the evaluation, the UK consultants had not had direct access with country co-ordinators and their point of contact with MeTA had been through the Operations

Director and the TA responsible for surveys. There has been no direct contact with countries, with WHO Geneva or with the Wageningen staff who ran the Multi Sectoral workshop in Jordan. IDS have had access to evaluation materials from the Jordan workshop however.

The survey is designed to build on assess how current MSH groups are performing but to also survey additional organisations and individuals who could potentially contribute to MeTA in country but who are not yet involved.

As this work has some synergy with the input from Wageningen (who have been contracted to carry out a assessment of current needs of the MSH groups), it would seem desirable for there to be direct communication to share information, lesson learning and ensure that duplication is avoided.

18.4 Additional Information

There is a significant volume of information either already available in countries or becoming available shortly. The evaluation needed to be done at this stage which is before project completion to inform future plans but it is recognised that there is much information in the pipeline over and above what has been finalised by February 2010. The totality of information at this date is detailed below. Much of this originates from allied initiatives including the "predecessor" DFID funded WHO/HAI project or from current WHO programmes such as GGM. The WHO/ HAI project made information on prices available and this work has been continued under MeTA in Uganda.

It is sad to note that, whilst other initiatives may be generating information, there is not always a willingness to work collaboratively. MeTA Jordan and MeTA Philippines work collaboratively with GGM but, despite the MOH/GGM reports in Zambia being shared for the purposes of the Data Desk Review and Disclosure Survey, MeTA Zambia experienced considerable difficulty in being invited to participate in the National Medicines Review Process which is seen as MOH/PRA/ GGM owned, even though this will result in valuable information on the national approved medicines list.

One of the initiatives with considerable potential is the work in Ghana extracting information from the National Health Insurance Authority database. There are similar opportunities to work with insurers in the Philippines and Peru. In Jordan, there are plans for wide scale follow-up of preliminary work on standard treatment guidelines and the processes surrounding the Rational Drug List.

National health insurance and medicines – MeTA Ghana helps to analyse the issues

The National Health Insurance Authority houses a great deal of data because of its role in assessing and reimbursing claims. Its database is routinely used to meet the immediate practical needs of the Authority.

The database has the potential to provide information on a wide range of issues – much of this potential is currently not being exploited, as the Authority concentrates on

developing its core functions.

Some of the currently unexploited potential of the data is of great interest to the NHIA – particularly information about prescribing that does not follow the guidelines for rational use. This is important because insurance reimbursements for drug costs are escalating – from about 7% in 2005 through 39% in 2007 to an estimated 60% in 2010. Problems include widespread non-adherence to the approved medicines list, spurious claims and irrational prescribing.

MeTA Ghana is providing expertise and time to extract relevant information from the database. The NHIA have agreed on a list of indicators for which information can be extracted from the data. Some of the indicators were proposed by MeTA Ghana, others by the NHIA – both organisations have an interest in the outputs of the analysis.

The indicators include:
- 1 average number of items per prescription
- 2 % prescriptions with iantibiotics
- 3 % prescriptions with injections
- 4 Total drug cost as a % of total claims cost
- 5 Drug cost by therapeutic class.

In a (PowerPoint) presentation to the MeTA Ghana Forum in 2009, the Director of Claims at the NHIA (who is a MeTA Council member) described the joint NHIA/MeTA work as follows:

- 1 "Make NHIS medicines data available to MeTA for analysis
- 2 Data analysis will help form evidence-based policies
- 3 Collaborate with regulators (MeTA members) to enforce existing policies and guidelines of MOH."

18.5 Successes and Good Practice

It is encouraging that information is becoming available in countries which should provide the material for real discussions in MeTA councils. Even more will become available in the last six months of the pilot. There is evidence that all countries have now moved on to the second stage of MeTA evolution which involves the identification of catalytic information. As the table below demonstrates, not all of this has yet been disclosed but there is progress in this direction.

It is encouraging to see that, in some countries, different but allied initiatives are working together; thus in the Philippines there is close collaboration with GGM and GGM awards were presented at the MeTA forum.

18.6 Barriers, difficulties and lessons learnt

In all countries there is a considerable volume of information already available (see table 9). Some of this has been produced outside MeTA but, never the less, has relevance to

agreed objectives. One of the problems in some countries (such as Uganda) is that the value of this information is not fully exploited and, in both Uganda and Zambia, there is limited capacity to undertake synthesis locally to make the information more understandable/ accessible. In Zambia, this has been associated with difficulties in mobilising and managing local technical capacity.

A number of different initiatives are producing information relating to access, price, quality, availability and promotion. There is a tendency amongst all initiatives to "badge" this information as belonging to a particular project or funder. In just the same way as sectors in MeTA need to share information, it is equally important that there is sharing of information within countries recognising that, ultimately, the goal is to achieve policy and behaviour change to increase access to appropriate good quality medicines.

The country case studies identify that, in many countries, there are multiple players working to improve access to pharmaceuticals. MeTA in financial terms is a relatively small initiative and it is therefore particularly important that its very particular aims are articulated clearly. Only when other programmes and initiatives understand MeTAs aims and way of working will they be prepared to share information. There is also the potential to share in country expertise.

Whilst some countries (notably Philippines, Ghana and Jordan) have access to specialist support to both analyse and quality assure information, this is not the case in all countries. Lack of appropriate competences in interpretation resulted in a quarterly pricing review containing inaccurate and misleading information in Uganda. Fortunately, this was recognised and the Council has now provided internal QA support for all material being released. However council members undertake this role voluntarily and it is not reasonable to expect them to undertake substantial, detailed input over and above their full time jobs. **There appears to be a need in a number of countries (Kyrgyzstan, Zambia and Uganda) to employ specialist local consultants (possibly with an academic, research or statistics background) to perform external validation where this is not an integral part of existing surveys.**

In most countries and certainly internationally, MeTA has not yet made sufficient investments in information technology to cope with the large amounts of data that will be disclosed and collected. **A well functioning information management system to collect and disseminate data, in a timely way and in a useful format, is imperative for accountability. There may be opportunities to use partner organisations (particularly in academia) to achieve this.**

Key Findings

MeTA has both used tools from predecessor initiatives and developed new tools. In each country a significant body of information exists, some of it generated from predecessor or complementary programmes.

19. Progress towards disclosure

There has been some disclosure taking place in a number of countries and all countries are making some progress towards identifying what information might be catalytic to achieve change. The table 9 below provides a summary of this.

However, insufficient thought has been given to the meaning of disclosure. There is an urgent need to provide support to countries to identify who will be the users of information and which will be the best way to access this.

In Uganda, MeTA has supported the National Drug Authority in creating a website on which the register of approved drugs is displayed. In the past, this information was perceived as publicly available because it could be bought in CD form for a sum of approximately $500.

The new website makes this information available free to any person with internet access. The stated aim of the activity was to make this information available to end users so they could check whether medicines were registered or whether they had been imported illegally and were therefore likely to be counterfeits. In practice, it is highly unlikely that end users will currently have internet access and, even if they do, the volume of information on the site means that it is unlikely to be useful for the stated purpose.

The real users of this information are actually private sector manufacturers and importers who can identify gaps in the market. They were prepared to pay for this information in the past but may see it as a quid pro quo for providing cost information in the future

The real benefit of the NDA website will come when the register also includes details of price at point of import or factory door. This will allow markup to be calculated and enable pressure to be exerted to control this. Even then it is unlikely to be the end users who will access the information but CSOs and others will need a comparison study undertaken using the import price and the retail information from the pricing surveys

One of the problems is that there is a perception that information is “owned “by other initiatives such as GGM or HAI and cannot be used by MeTA. It is important to recognise that the aim is to create a repository of good quality, up to date information, regardless of source, which can be accessed by all interested parties.

“The medicines family is a global small family…we must get on together and share”

In the coming months a large volume of information will become available. The disclosure surveys have all been completed and councils should have a good overview of what is available.

It is of the highest importance however that countries should not feel pressured to disclose until they are satisfied that the information is of good quality and until they have considered how to maintain a flow of information in the future.

Information relating to the Philippines FDA in the disclosure document appears to have been presented in London and Manila before verification was completed and the most recent Ugandan pricing survey was circulated without basic calculations being checked**. MeTA must have a reputation for the quality of the data it uses to be credible.**

Table 9. Survey Information available as of 28.02.10

Country	Information	Source	Date	Disclosed
Ghana	Level 2 Facility and household survey (draft)	MeTA/MOH/WHO/	2009	No
	Pricing and price component study (draft)	WHO/MOH/ HAN	Ongoing	No
	FDB mini lab quality surveys	FDB, MeTA WHO	2010	No
	Antibiotic Study (WB Funded)	FDB/ MeTA	Ongoing	No
	Procurement and Supply mapping	MOH/WHO	Ongoing	No
	Disclosure survey	MeTA	2010	No
	Supply Chain Mapping	Rockefeller Foundation	Pre MeTA	Published and available on Rockefeller's website
Jordan	Level 2 Facility survey	MeTA/ WHO/MOH/ DOS		No. Workshop dates set
	Household survey	MeTA/ WHO/MOH/ DOS	Ongoing	No. workshop date has been set
	Assessment Good Governance and Medicines	WHO/ MOH	2009	Yes
	Pricing Survey	HAI	2007	Yes
	Disclosure report	MeTA	2010	Yes
	Private Sector Mapping	MeTA	2009	Discussed within META
	Civil Society Mapping	MeTA/ CSO coalition	Ongoing	No
	Supply Chain Mapping	WB/ MeTA	Ongoing	Not yet public on Website
	Medicines Procurement Assessment	MeTA/ WB	Ongoing	No
Kyrgyzstan	Assessment of DRA	MeTA / WHO	2009	Information shared internally only
	Survey of Quality of Medicines (samples collected)	MeTA/ WHO	Ongoing	No
	National Drug Formulary (draft produced)	MeTA/ WHO/ WB/ MOH	Ongoing	No
	Prescribing survey (design agreed)	MeTA/ WHO	Ongoing	No
	Pricing survey	WHO/HAI	2005	Available only in

				English and not used by nationals
	Disclosure survey	MeTA	2010	No
Peru	Peruvian Medicines Price Observatory	MOH/ WHO/ HAI	2007	Scheduled
	Pharmaceutical Assessment	???	2006	??
	Disclosure survey (not in standard format)	MeTA	2010	No
Philippines	Level 2 Facility and household Surveys	MOH/WHO/MeTA	Ongoing	No (initial results of survey to council Aug 2009)
	Survey of components of Medicine Prices	HAI/ WHO/ DOH/	??	Yes, on HAI website
	Civil society mapping survey	CSOs	2009	Yes amongst CSOs
	Bench Book (standards for accrediting facilities)	PHIC/WHO/MeTA	2009	Yes with pilot facilities
	Study of Public Procurement Prices	MeTA/WB	ongoing	No
	Disclosure survey	MeTA	2009	No
Uganda	Medicine Pricing surveys	MOH/HAI/WHO (08) MOH/MeTA (09)	2008 ongoing	Yes No
	Household survey	WHO/MeTA	2009	Yes
	Facility survey	WHO	2008	Yes
	Communication materials on RUM	WHO/MeTA	2009	Yes but associated activities not started
	NDA registration information	MeTA/NDA	2009	Yes online but not updated and price and quality not yet included
	Disclosure survey	MeTA	2010	No
	Private Sector Mapping	MeTA	2009	Discussed within META
Zambia	Assessment of procurement and supply management systems (draft)	MOH/WHO	2009	No
	Good governance for medicines	WHO	2008	No
	Mapping of partners in procurement and supply management of essential medicines and supplies (draft)	MOH/WHO	2007	No
	Pharmaceutical sector baseline survey	MOH/WHO	2006	No

	List of registered medicines	MRA	2009	Yes
	Disclosure survey (draft)	MeTA	2010	No
	Private Sector Mapping	MeTA	2009	Discussed within META

19.1 Successes and Good Practice

Table 9 demonstrates that already information is coming into the public domain and there is the potential for a significant volume to be shared in the coming months. This will be most successful where the purpose of disclosure (rather than disclosure for disclosures sake) has been identified. There are external opportunities such as strategic planning and budgeting reviews, times of political change etc when the use of information can be particularly catalytic. MeTA councils are positioning themselves to take advantage of these external opportunities through

- Setting the precedent of multi stakeholder involvement in national budgeting and planning (Uganda)
- Having access to the highest level of policy making (Jordan, the High Health council)
- Engaging with politicians (Zambia)

19.2 Barriers, difficulties and lessons learnt

Inevitably progress is variable in countries, with those who have been established longest demonstrating most progress. However, disclosure is not merely a matter of time or of obtaining quality assured information. The major facilitating (or inhibiting) factor is the attitude of key stakeholders, most notably government. Where there is an environment informed by a government's public commitment to transparency, it is more likely that MeTA councils locally will feel able to agree a basic data set and to move towards ensuring disclosure and use for advocacy and behaviour and policy change.

However in at least two of the MeTA countries the current political environment is less likely to support disclosure, particularly of information which is seen as "sensitive". It is suggested that under these circumstances, it is unlikely that major progress will be made in achieving MeTA goals until the prevailing environment changes. There is still a role for disclosure by the other sectors and follow up with advocacy for policy change recognising that this can, if well orchestrated, achieve political change.

It was recognised at design stage that in addition to the enormous gains, there were also potential risks in encouraging transparency. It is important to ensure that these risks are recognised in countries and risk management is practiced. There are real and genuine fears about what information may be made available and how this is done. MeTA is promoting the disclosure of strategic, quality assured information; it is **not** promoting a whistleblowers charter where individuals are asked to make allegations (which could be unfounded) concerning poor practice. The distinction is very important and an understanding of this in all countries would create greater trust in those who are currently unconvinced or fear this could happen

Key Findings

Countries have all completed a disclosure survey which identifies what is publicly available. This survey has the potential to help councils identify ownership of information, priorities for disclosure and existing gaps. Some information is

already in the public domain but it will be important to ensure rigorous verification/ quality assurance and to work with key stakeholders including other programmes to establish ownership and access.

20. Progress towards Changes in Policy and Business Practice

The MeTA hypothesis proposes that by making information more available it will be possible to influence and change policy and business practice. The MeTA pilot has been operating for under two years and it is generally felt to be much too early to evaluate whether this hypothesis is proven or whether there are indications that there is potential.

Certainly it is not possible to identify many specific examples of legal change, policy change or business practice and attribute these solely to MeTA. In many cases it is felt that MeTA may have contributed to changes which were already in the pipeline or may have speeded up initiatives by providing input. In some cases this may have been opportunistic rather than planned and prioritised but this is a sensible, flexible and pragmatic way to work.

In the Philippines, Council members were involved in the national debates (and apparently quieter lobbying) over two pieces of legislation passed in 2009 – the Food and Drug Administration Act (9711) and the Affordable Medicines Act (9502), as well as Executive Order 821, which set maximum drug retail prices. Some MeTA Philippines members (e.g. Dr Lazo) apparently helped draft 9502 and MeTA organised for academics to address hearings and bicameral negotiations on the law. It is difficult however to evaluate the effect of MeTA activities as there were no MeTA recommendations and indeed council members appear not to have adopted a common line of advocacy. Views of council members vary from *"without MeTA there might have been no laws" to "*MeTA *has zero influence on policy"*

Some interviewees expressed disappointment that MeTA Philippines did not use the debates around these laws to draw more attention to itself and present forthright views. And the chair admits that 9502 eventually has done almost nothing to improve access to medicines for the poor as although expensive branded drugs have reduced in price (and this has benefited the better off) they are still out of range of the poor. It must be recognised however that, especially with the issue of pricing, it is difficult for MeTA Philippines to find consensus. Perhaps more importantly at this relatively early stage is the fact that council members were engaged in legal change and this sets a precedent for the future.

In Peru MeTA was instrumental in moving towards the creation of a National Price Observatory as identified by the MOH and included for funding in their workplan. This was implemented by the government issuing regulations before MeTA recommendations were finalised. Some stakeholders perceive this as a "highjacking" of a MeTA initiative but an alternative view is to see it as a major success in achieving institutionalisation.

In Jordan, MeTA work with the UK National Institute for Clinical Excellence (NICE) funded through the WB, has resulted in the development evidence-based standard treatment guidelines for hypertension. Another stream of work has revised the ways in which the Rational Drug list is reviewed. There are now major challenges to ensure

widespread adherence, at least in the public sector, to the treatment guidelines and Drug List.

These changes to policy may be small in themselves but they are "indications" that MeTA has the potential to achieve change

20.1 Barriers, difficulties and lessons learnt

Disclosure and the use of information has the potential to lead to changes in policy and business practice but it must be recognised that there may be local situations which are perceived as not amenable to this approach. In Jordan, the way in which local private sector prices are set is a good example of this. Pricing is one of the most contentious areas within the MeTA Council, with a feeling that to challenge the acknowledged high prices paid in Jordan is to inappropriately threaten Jordan's exports. Locally manufactured pharmaceuticals can be sold in the private sector in Jordan with high profitability. This is a deliberate (and transparent) strategy of the Jordanian Government to protect the important local industry, and to enable it achieve higher prices for its exports. The method for setting local prices is disclosed, but there is a widespread feeling that the method is unchangeable.

Key Findings

It is too early to expect MeTA to have achieved major changes in policy or business practice. However, there has been legislative change in the Philippines where MeTA members were clearly contributory and also work in Peru (the Price Observatory) which was a joint initiative with government. Work on effective medicines for the Rational Drug List in Jordan and amendments to guidelines on hypertension have also been significant. Involvement of the private and civil society sectors in strategic planning for medicines in Uganda sets a useful precedent. These are useful "signs in the sky" indicating the potential of MeTA.

So far, no changes have been identified in business practice. Whilst the private sector is involved in each country forum, there is a feeling in some countries that their involvement is driven by a wish to achieve particular business results (e.g. changes in tax application etc). Whilst there is no identification of disclosure which gives mutual benefit (win: win) there is a danger that all parties are not benefiting equally from discussion and the end users of medicines may not be the winners.

21. Progress towards Logframe Purpose Level Objectives

The logframe identifies the following milestones which need to be met at purpose level. There appears good evidence that these admittedly modest milestones are likely to be met.

Table 10. Progress against purpose level objectives

Purpose	Indicator	Milestones	Evidence
Strengthen capacity of countries to collect, analyse and disseminate data on price, quality and availability of medicines; and use evidence to improve the efficiency of public and private pharmaceutical markets.	The number of pilot countries disclosing validated data on the price, quality, availability and/or promotion of medicines in the public domain.	1 (Dec 2009) 2 (June 2010) 3 (September 2010)	**All countries have collected data and validation, analysis is being undertaken in Philippines, Ghana and Jordan.** **These milestone are likely to be met although data will not be available in all four areas (price, quality, availability/ promotion)**
	The number of pilot countries formulating change in policy and/or business practices driven by issue prioritisation and data analysis supported by multi-stakeholder groups.	0 (Dec 2009) 1 (June 2010) 2 (September 2010	**There are indications that these milestones will be met in respect of policy change in Jordan and the Philippines although the scale will initially be very small. However there are precedents being set which will enable Uganda MeTA council to further engage in policy formulation.**

In the longer term, it is more difficult to predict whether these purpose level objectives will be met in all countries. It seems likely that, with continuing financial and technical support and some strengthening of the capacity and capabilities of the country secretariats, the majority will certainly identify priorities and collect, validate and disclose

information. It may not be possible to obtain information relating to price, quality, availability and promotion in all countries and sustaining a continuing flow of quality information will be challenging.

Where there is a strong relationship with the MOH or equivalent, there is a strong likelihood that MeTA will be able to achieve policy change particularly relating to rational use of drugs, increased use of generics and possibly quality. However, this will be much more difficult where engagement with the MOH is less strong. In general, public sector policy relating to drugs will stem from the MOH and engagement at both political and departmental level will be essential. Elections resulting in political change have the potential to affect these relationships.

Whilst the private sector is actively involved with MeTA, there are fewer indications of a willingness to consider changes in business practice. With stronger buy in from international manufacturers and their engagement at country level, it appears that it might be possible to agree stronger codes of practice concerning promotion at country level. Currently country level policies appear to be less rigorous than those agreed internationally.

Key Findings

The MeTA pilot has achieved the purpose level milestones in the logframe up to date and there are good indications that all milestones up to September 2010 will be achieved. There also appear to be clear indications that progress is accelerating.

21. Are the Hypotheses Proven?

There has been a recognition from the start that it was unlikely that the hypotheses underpinning MeTA could be proven in a short pilot period. Certainly MeTA councils can demonstrate that multi sector engagement is building both greater mutual understanding and a degree of trust amongst the individuals concerned. This is starting to pay dividends but in some countries it is proving harder to get all three sectors represented strongly. The reasons for this are different in each country;-

- The private sector in Kyrgyzstan is very dispersed and not organised
- Civil society in Jordan is building on a weak base despite considerable efforts
- The MOH in Zambia has recently experienced a major scandal and is in the process of rebuilding
- The public sector in Ghana currently do not wish to be involved more.

There are good indications and some hard evidence that this trust is leading to greater transparency and a willingness to identify and collect relevant information and there are plans to disclose this information although the exact methodologies may not be finalised in all countries. As yet, much of this information is generated by surveys and there are not sustainable, institutionalised plans to ensure onging updating and disclosure. Perhaps understandably, the emphasis in some countries has been on the collection of data, rather than how it can be used in a public arena to achieve change. The disclosure surveys have identified significant available information and it seems likely that the last six months of the pilot phase will see this shared widely.

It is not yet possible to attribute major policy or business practice change to MeTA in any country although there is a good indication that MeTA Philippines is already establishing itself as a player in the policy arena. Jordan has excellent links with very high level policy makers and is tackling big issues around access to medicine and there are hopeful indicators in Peru. The involvement of the private and CSO sectors in strategic planning in Uganda is an equally helpful precedent.

In all, a great deal has been achieved both nationally and internationally in a short period of time and there appear to be clear "signs in the sky" that progress is accelerating.

"Great value and huge potential. I think that this has still got legs."

"MeTA potentially is a vanguard model; the transparency world are watching this carefully"
IAG members

The problems in the performance of the IMS need to be separated from the general adoption of the principles and achievement in countries. There is evidence that countries are perceiving the benefits and potential benefits of MeTA and this may increase with more information becoming available shortly and some workplan activities coming to fruition.

The difficulties in establishing the infrastructure and agreeing the workplans has undoubtedly taken up much national time and effort and it appears that this could have been abbreviated with increased support from the IMS and TA. The problems, where they exist, do not appear to be so much to do with the principles than with the implementation. Only in one area is there still a need for more evidence and this is in the involvement of the Private Sector. Whilst there are indications of the potential of their involvement in the multi stakeholder process, actual outputs are lacking.

22. Looking to the Future

DFID indicated at the creation of MeTA that, should the pilot phase prove successful, then a further tranche of funding was available to continue for a total of ten years(i.e. until 2018). This evaluation will provide some of the information on which the decision will be made. There are a number of big questions, as follow, which will need to be considered if MeTA 2 is agreed.

22.1 Funding mechanisms and identification of new funders

DFID are currently exploring the possibility of identifying additional funders. If this is to be successful, it is important that there is an agreed, consistent message being disseminated by all current members of the Alliance as to

- What is the clear value proposition? (i.e. MeTAs unique and particular contribution)
- What will be the gains?
- What will be the incentives for all the key stakeholders
- How will success be measured?

The current funding modality has channelled money through three separate agencies and, at times, this has created problems because ultimately it is not possible for WHO and the WB at HQ level to specify how resources are used at country level. There have been issues concerning transaction costs of contracting but also of disbursement and delivering activities on time. Both partners have considerable strategic significance and bring both expertise/ experience and also parallel projects which complement MeTA. It seems important to retain this strategic involvement but to recognise how their comparative advantage can best be used and how to ensure it will be delivered.

If new funders are identified, it will be essential to ensure that there **is a shared understanding of the MeTA principles and a shared vision of what can be achieved**. This cannot be taken for granted and some form of facilitated exercise to agree both rules of engagement and basic principles seems desirable.

There has been discussion about private sector funding for MeTA. This would not be unique and would be in line with other forms of public / private partnership. However, given some of the key players, particularly WHO and some of the international CSOs, this would require careful exploration as there are indications that some might not feel able to continue to support MeTA if it was funded in this way.

22.2 Governance arrangements

There have already been proposals put forward about future governance arrangements and assessing these is outside the scope of this evaluation. However as indicated earlier, there appear to be a number of factors which should be applied when examining

future arrangements.

The MMB needs to separate oversight from operational involvement and be clear about the respective roles of the alliance partners and the executive (Secretariat).

The current IAG may not yet have made a major impact but organised differently (perhaps using time limited working groups to advise on specific issues) and used in a different way (to include some individual mentoring and coaching perhaps) it appears to have huge potential.

At country level there would appear to be a need to provide a basic governance support package including suggestions for the constitution of the multi-stakeholder Forum/ council and model job descriptions, proforma reports etc. this would allow current councils to all meet a basic standard of good governance and would enable new countries to get running faster. There would be no requirement to use the model but it would provide a template.

22.3 Identification of new countries

Undertaking the pilot in seven countries was extremely ambitious particularly given their geographic spread which increased support costs and made country to country contact more difficult. **Consideration will need to be given to how realistic it would be to have a tranche of new countries coming on board at this stage. These countries would be at a different stage of development and would need a parallel programme of support addressing their needs (setting up multi stakeholder forums etc), which would differ from the needs of existing countries who have moved beyond this stage It might be worth considering a second tranche of countries all being in geographical proximity to reduce support costs and encourage mutual support and learning. They could be supported on a south:south base by one of the existing countries.**

If the decision is made to engage additional countries then clearly willingness to commit to MeTA principles is the main requirement for a new country but the experience of the pilot suggests that there may be other criteria which will mitigate towards success. These might include:-

- The government and MOH having a proven attitude to transparency and a willingness to put information into the public arena which holds them to account
- The pharmacy division of the MOH able to engage and not already committed to a major DP funded project which allows little time for other initiatives (as is currently the case in Uganda)
- Other complementary work identifying information already being in place and willing to work collaboratively (GGM/ HAI etc)
- Local representatives of DFID, WHO, the WB and any other partners being enthusiastically supportive and prepared to “open doors”

- A private sector organised in such a way that it can have representatives of all aspects of private sector activity (i.e. one or more associations who can represent manufacture, import, wholesale, distribution, retail and private sector prescribing)

- A strong CSO sector with the potential to work together

- Consideration needs to be given to whether it is realistic to work with a country where English is not the first language. Support material is currently in English and there is no current budget for translation. Both the WB and WHO have this capacity however and if translation were possible into (say) French, Spanish, Russian and Arabic it would widen the potential pool of countries.

22.4 Whether to continue support to existing countries

Existing countries are at different stages and have differential levels of achievement. Whilst all appear very enthusiastic, the question must be asked, to what extent are they demonstrating potential to succeed? This is not a matter of the degree of effort but may be due to the current country context. If there is a lack of high level / political support and if the current government is not committed to transparency or to changing policy, then it may be the wrong time to pursue this initiative. However, active support from other sectors including academia and possibly other DPs might make it worth continuing. It would clearly be difficult to withdraw support but it might be appropriate to request some practical indication of commitment before investing further (i.e. not just a letter of commitment).

22.5 The design and identification of the secretariat function

The secretariat has a number of different functions and requires knowledge and expertise in a number of different areas. Whilst not wishing to be prescriptive it would seem important that any future body meets the following criteria

- It is a single collocated organisation preferably with a track record of delivering multi country programmes

- It has both demonstrable expertise and networks for supporting programmes in the field of medicines

- It can provide a professional manager to lead the programme with experience in managing international programmes of this size and complexity

- It has already developed finance, performance management and monitoring systems suited to the contract type (e.g. service and fee).

22.6 What might be different?

The current IMS have based their support on a strict principle of countries leading and deciding whether or not they require support or whether to use the tools and materials on offer. Whilst this is clearly desirable it presumes a level of knowledge and experience which may not exist in a new organisation with no experience of working together across sector boundaries.

It is therefore suggested that **there is an understanding established from the beginning that countries are signing up to an approach which incorporates established proven approaches and good practice and that, by adopting MeTA principles, countries are buying into a model which is based on experience**. Clearly, counties may, over time, decide to vary the model to adapt to local circumstances but there **should be an expectation that consideration would be given to using the "MeTA Framework and Approach**"

The pilot phase was not able to sequence activities in a sensible order purely because some of the tools were not available. Learning from this experience it is suggested that **key events might be delivered in a different order**

- The CSO Capacity building activity could be offered very early to enable CSOs to identify potential members of the council (this was delivered in February and July 2008)

- The Harvard Flagship course could be offered at an early stage to build a common platform of knowledge and skills in country teams. It could incorporate some "Country Sharing" from existing MeTA countries.

- The disclosure tool could be supported as the first activity **prior** to workplanning. The workplans would fall out of priorities identified in the disclosure document

- Surveys using the standard tools could then be undertaken to fill gaps as necessary and to establish a comprehensive baseline.

Annex 1: Interviews for Main Report

Abu el Salem Taher	Member of IAG (Jordan)
Arce Elias	Member of IAG (Peru)
Atun Rifat	GFATM and previously Imperial College London
Back Emma	TA Ghana
Baghdadi-Sabeti Guitelle	Technical Officer MAR WHO (GGM)
Bannenberg Wilbert	MeTA International Secretariat (Technical Director)
Banzon Eduardo	World Bank Philippines
Bermudez Jorge	Executive Secretary UNITAID
Borowitz Michael	Formerly DFID Health Adviser
Brandamir Elodie	MeTA International Secretariat (Operations Director)
Calland Richard	Institute for Democracy in S Africa
Cameron Alexandra	Technical Officer MAR WHO
Chetley Andrew	Healthlink Worldwide (Director Communications and CSO)
Claire Innes	DFID
Creo Clare	Technical Officer PRP/RMS WHO
Dunn Alison	Healthlink,Worldwide MeTA International Secretariat (Communications Manager)
Elliott Bryan	MeTA International Secretariat (Executive Director and Private Sector)
Fidler Armin	World Bank
Forte Gilles	WHO
Graymore Daniel	DFID
Green Carolyn	TA International CSO Strengthening
Hawkins Kate	IDS Sussex (Survey component 3)
Hawkins Lorraine	Former TA and scoping survey
Hogerzeil Hans	Director EMP WHO
Innes Claire	DFID
Jamieson David	Supply Chain Management Systems
Laing Richard	WHO/EMP
Lungu Goodwell	Zambia IAG member
McHale John	Fidelity Management and Research Inc
MeClasky Jeff	MD, HPI
Murphy Geraldine	DFID
Ombaka Eva	Ecumenical Pharmaceutical Network
Perkins Nick	IDS Sussex (Survey component 3)
Reed Tim	HAI
Reich Michael	Harvard Flagship Course
Roberts Marc	Harvard Flagship Course
Ross Degnan Dennis	Harvard Collaborating Centre

Saad Samia	TA (international) Jordan and Baselines
Santerre Frederique	IFPMA and IAG member
Seiter Andreas	World Bank
Seru Morries	Uganda IAG member
Strong Kate	M and E Officer UNITAID
Tata Helen	Technical Officer MPC WHO
Tickell Sophia	Chair IAG
Walker Saul	DFID
Wickremasinghe Deepthi	MeTA Secretariat (Communications Manager)

Formal Meetings attended

Country Sharing Meeting	December 2009
IAG 3rd meeting	January 2010
Jordan Flagship course and MSH Workshop	January 2010
MeTA Management Board	March 2010 (by telephone / Skype)

Annex 2: Summary of Current Initiatives

Name of Institution	Programme	Website	Description of activities
Bilaterals			
Canadian International Development Agency (CIDA)	Donations of Medicines Eligibility Program 2008-Current	http://www.acdi-cida.gc.ca/acdi-cida/ACDI-CIDA.nsf/eng/JUD-62594147-J3N	In the 2007 federal budget, it was announced that companies that donated medicines to Canadian registered charities for use outside of Canada would receive tax breaks. This programme aims to ensure that donations of medicines to developing countries are appropriate, demand-driven and based on clear evidence of need within the population.
German Federal Ministry for Economic Cooperation and Development (BMZ)	Sector Strategy: German Development Policy in the Health Sector 2009	http://www.bmz.de/en/service/infothek/fach/konzepte/konzept187.pdf	BMZ's recent sector strategy for health stated that is would provide support to enable its partners to fully utilise existing flexibilities afforded by the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) in the health sector and expand the local pharmaceutical industry through institution-building approaches. Local production of drugs to treat poverty-related diseases is also being supported.
Netherlands Ministry of Foreign Affairs	General	http://www.minbuza.nl/en/Key_Topics/Millennium_Development_Goals_MDGs/Dutch_aim_for_MDG_8	At the end of 2004, it became the first EU member state to export affordable medicines to developing countries. The Netherlands is advocating an EU scheme for affordable medicines that is as flexible and wide-ranging as possible. They also supported Thailand's use of compulsory licenses for patented medicines, ensuring that at the EU level, Thailand could make use of this TRIPS flexibility.
	Noordwijk Medicines Agenda 2007	http://www.oecd.org/document/45/0,3343,en_2649_34537_39163757_1_1_1_1,00.html	In 2007, emerging from a high level meeting organised by the Norwegians, the Noordwijk Medicines Agenda is a consensus document which aims to act as an incentive to improve access to essential medicines and vaccines.
DFID	Various policy papers and reports	http://www.dfid.gov.uk/Global-Issues/How-we-fight-Poverty/Health/Access-to-Medicines/	DFID have produced a number of policies and papers relating to access to medicines. These include Increasing people's access to essential medicines in developing countries: a framework for good practice in the pharmaceutical industry (2005) http://www.dfid.gov.uk/Documents/publications/pharm-framework.pdf and Policy paper, Increasing access to essential medicines in the developing world: UK Government policy and plans (2004) . This framework provides guidance to

			pharmaceutical companies on differential pricing and improving ATM http://www.dfid.gov.uk/Documents/publications/accessmedicines.pdf
	The high level Working Group on Increasing Access to Essential Medicines in the Developing World 2001-2002		The working group consisted of members of the UK government, the pharmaceutical industry, the European Commission, WHO, WTO, academic institutions, charitable foundations and developing countries. The main aims were to develop specific steps the UK could take to support R&D for diseases affecting developing countries. An outline was developed on steps towards a global framework to facilitate voluntary, widespread, sustainable and predictable, differential pricing by pharmaceutical companies. The group concluded that differential pricing was a viable option with prices in SSA to be set close to cost price. The working group was chaired by the Secretary of State for Development (Claire Short) and reported to the Prime Minister in November 2002, report at http://www.dfid.gov.uk/Documents/publications/accessmedicines-report281102.pdf
	Southern Africa Region Programme on Access to Essential Medicines (SARPAM) 2009-2013		SARPAM aims to reduce the disease burden in Southern Africa by increasing access to affordable, essential medicines. Through building local capacity, it aims to improve the availability, affordability and quality of essential medicines and diagnostics. In its inception phase, SARPAM aims to 1) establish a baseline for the programme 2) confirm the potential impact of the regional level working to address access to medicines 3) build the capacity of SADC to implement the programme. There is also an aim to strengthen relationships between SADC and its stakeholders. SARPAM's business plan outlines its hopes to harmonise treatment guidelines and essential medicines lists across SADC; Strengthen medicines regulatory capacity; Promote joint procurement (or similar approaches that achieve cost savings); Develop and retain competent human resources in this specialist area; Establish mechanisms to respond to emergency pharmaceutical needs; and Facilitate trade in pharmaceuticals across the region.

USAID	General	http://www.usaid.gov/our_work/global_health/hs/techareas/commodities.html	USAID improves the availability and use of quality health commodities, such as pharmaceuticals, vaccines, medical supplies, and basic equipment, through the following strategies: Working with policymakers, researchers, managers, and providers in both the public and private sectors to identify within health commodity systems the root causes of ineffective supply, poor access, and inappropriate use; Collaborating with these partners to implement new and proven approaches to address these problems; Expanding on proven commodity management methodologies and tools for global technical leadership, regional initiatives, and country programs; Rethinking the roles of the public and private sectors in service provision and regulation; Improving the financial sustainability of commodity systems and strengthening their operational efficiency; Training public health workers and health professionals in drug information and pharmacotherapy to improve competence and accountability in drug dispensing; Developing and disseminating evidence-based drug and therapeutic information; Strengthening medicine quality assurance systems, including post-marketing surveillance; Providing support to Good Manufacturing Practices (GMP) compliance in the manufacturing of medicines relevant to USAID priority health programs
	USAID | DELIVER Project 2000 - present	http://deliver.jsi.com/dhome	DELIVER assists with the development of health supply chains for numerous essential health commodities including: family planning, malaria, avian influenza, HIV and AIDS-related medicines and supplies, laboratory reagents and supplies, and essential medicines. DELIVER aims to improve essential health commodity supply chains by strengthening logistics management information systems, streamlining distribution systems, identifying financial resources for procurement and supply chain operation, and enhancing forecasting and procurement planning. Policymakers and donors are encouraged to support logistics as a major factor in the success of health systems. The project is implemented by JSI who design, develop, strengthen, and, upon request, implement safe, sustainable, and reliable supply systems that provide a range of affordable, quality essential health commodities, including drugs, diagnostics, and supplies, to clients in country programs. Technical support is offered to strengthen all aspects of the supply chain

	Supply Chain Management Systems (SCMS) 2005-present	http://scms.pfscm.org/scms	SCMS is funded by PEPFAR and procures essential medicines and supplies at affordable prices; supports the building and strengthening of secure and sustainable supply chains and enhances stakeholder coordination. SCMS helps to reduce essential medicines prices by working with clients to carefully plan future procurement and pooling orders, enabling it to buy in bulk. Long term contracts with suppliers including generics manufactures can be established. Forecasted quantities of the most frequently requested items are stored at regional distribution centres (in Ghana, Kenya and South Africa) which allows them to distribute supplies rapidly. SCMS works with existing systems rather than creating parallel systems. They also work to build local capacity, to enable in country partners to determine necessary responses. Transparency is promoted to ensure accurate and timely supply chain information is collected, shared and used to improve decision making while industry best practice is used.
	Strengthening Pharmaceutical Systems (SPS) 2007-2012	http://www.msh.org/global-presence/sps.cfm	This USAID funded programme which is implemented by Management Sciences for Health aims to improve governance in the pharmaceutical sector; Strengthen pharmaceutical management systems to support public health services; Contain the emergence and spread of antimicrobial resistance and expand access to and improved use of essential medicines. SPS is the follow on project of Rational Pharmaceutical Management Plus Programme. The technical areas covered have been expanded to include financing, pharmacovigilance, pharmaceutical care, integration of new health technologies, and increased use of the private sector, among others.
	United States Pharmacopeia's Drug Quality and Information Program (USP DQI) 2000-2010	http://www.usp.org/worldwide/	Working in USAID priority countries, USP DQI aims to: 1) Improve drug quality by sharing its expertise in the field of drug quality and working with local governments, USAID missions, the World Health Organization (WHO), and other partners to evaluate a country's readiness and capacity to provide necessary drug quality assurance 2) provide continuing education for healthcare professionals 3) provide access to current, evidence-based drug information based on the advice of its expert volunteers to develop targeted drug and therapeutic information materials for health care providers based on specific needs in addition to offering assistance in establishing and equipping local drug information centers 4) provide technical leadership for regional and international cooperation.

	Private Sector Program IQC (PSP IQC)	http://www.pspiqc.org/	Managed by the Office of Population and Reproductive Health (PRH), the PSP IQC will allow USAID missions and bureaus to easily access high quality TA and support for their activities in the private sector in health. The aim is to promote private sector strategies to expand service delivery and access to high quality reproductive health and voluntary family planning, and other key health products in developing countries.
Multilaterals			
GFATM	Affordable Medicines Facility- malaria (AMFm)	http://www.theglobalfund.org/en/amfm/	UNITAID and DFID fund this programme which is managed by GFATM. GFATM negotiates lower priced ACTs from manufacturers and pays a large proportion of this with public, private and NGO sector suppliers paying a much lower price. The first phase of proposals were invited from 11 countries including Ghana and Uganda.
	Guide to the Global Fund's Policy on Procurement and Supply Chain Management 2009	http://www.theglobalfund.org/documents/psm/pp_guidelines_procurement_supplymanagement_en.pdf	This guide provides the minimum standards for procurement and supply chain management that GFATM grant recipients, sub-recipients and procurement agents must adhere to. It is necessary for recipients to produce a supply management plan. Grant funds can budget for TA to assist with procurement and supply chain issues if necessary including to build capacity. To assist grant recipients, GFATM has set up procurement support services including a Voluntary Pooled Procurement mechanism and capacity building services and supply chain management assistance. Other standards that must be met concern quality assurance and complying with national regulations; establishment and management of a procurement supply cycle and the management of information systems.
World Bank (WB)	General		The World Bank (WB) works with technical agencies such as WHO and UNICEF, applying their expertise and learning in the pharmaceutical sector across organisations. They are represented on the management board of MeTA. WB also acts as the steward of multi-donor trust funds which analyse and provide TA in the pharmaceutical sector. There is a small team within the A small team within Health, Nutrition and Population of the Human Development Network (HDNHE) which focuses on strengthening the pharmaceutical sector in order to improve health outcomes. This team works with the World Bank's regional and country specialists to help design, implement and evaluate health projects with pharmaceutical components. At the country level, this translates into programmatic work, technical assistance and olicy dialogue. The team is lso responsible for

			tools designed for internal regional specialists and technical level staff in client countries. Finally, the team collaborates with the World Bank's Operations and Procurement to continuously improve and streamline procurement procedures. WB have also produced a number of assessment tools and policy briefs
	The World Bank's Global HIV/AIDS Program of Action 2005	http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1127498796401/GHAPAFinal.pdf	WB's Global HIV/AIDS Programme of Action states that it will provide financing and advisory services to improve local capacity for managing logistics of pharmaceuticals and other supplies, procurement and financial management, health management information systems, and health care waste management systems. It is also stated that the World Bank Institute (WBI) will continue to provide training to staff and clients in priority areas, especially program management, and ARV procurement and supply management, responding to country demand. WBI will focus on building implementation capacity for HIV/AIDS programs by: i) building the management capacity of the public sector and civil society organizations to overcome the current planning, management and implementation constraints, ii) continued collaboration with WHO, UNAIDS, Global Fund and PEPFAR to harmonize ARV procurement and supply management efforts at country level, iii) continuing to hold training workshops on procurement and supply management at regional and country level, iv) building the technical capacity of program managers using technology to rapidly disseminate evidence-informed knowledge across geographical borders, v) engaging high level policy makers to advocate for HIV/AIDS, and vi) building the capacity of ministry of health and ministry of finance officials to address the macroeconomic polices that might impede rapid scaling-up of HIV/AIDS activities. There is however no evidence of this work taking place.
G8 Health Action Plan		http://www.dfid.gov.uk/Documents/publications/pharm-framework.pdf	The Action Plan was a series of commitments to increasing access to essential medicines, including in relation to differential pricing, and commitments to address leakage and diversion, and to ensure G8 governments do not reference their own prices against those offered to developing countries

GAVI Alliance	Supply Strategy Group		The group was established to address issues related to price, supply and financing of vaccines for developing countries. The purpose of the group is to advise the Boards on the optimum supply strategy to consider for these vaccines to best leverage GAVI's comparative advantage.
Global Alliance to Eliminate Lymphatic Filariasis	General	http://www.filariasis.org/	Aims to bring together a diverse group of partners with the aim of mobilising political, financial and technical resources. Included in the alliance are two pharmaceutical companies (Merck and GSK) which have pledged to donate more than $1 billion worth of drugs with the aim of eliminating the disease. The strategy of the alliance is to apply mass drug administration (MDA) to reduce infection load, prevent new cases and recrudescence.
World Health Organisation (WHO)	Good Governance for Medicines Programme (GGM)	http://www.who.int/medicines/ggm/en/index.html	Funded by AusAid, Germany and the EC, the Good Governance for Medicines Programme (GGM), established in 2004 is working in 26 countries. GGM is guided by WHO's medicines strategy 2004-2007 and aims to prevent corruption and promote good governance in the pharmaceutical sector. The programme follows a three step approach which can be tailored to suit country contexts. Phase I: national assessment of transparency and potential for vulnerability to corruption- This is based on a standardised assessment which focuses on the central functions of pharmaceutical regulation and supply systems. Phase II: Development of a national GGM programme- based on phase one in addition to national consultations with stakeholders and experience from other countries, a programme is developed which can include components such as an ethical framework and code of conduct, regulations and administrative procedures, collaboration mechanisms with other good governance and anti-corruption initiatives, whistle-blowing mechanisms, sanctions for reprehensible acts and a GGM implementing task force. Phase III: Implementation of the programme- this involves institutional learning to ensure that new procedures are implemented and capacities are developed.
	International Drug Price Indicator Guide	http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=DMP&language=English	This price indicator which is published annually by Management Services for Health (MSH) in collaboration with WHO provides indicative prices on the international market of mainly generic drugs are recorded in addition to tender prices from nine national procurement agencies.

	Medicines Prices, Availability and Price Components 2000-present	http://www.haiweb.org/medicineprices/	See HAI
	Sources and Prices of Selected Medicines and Diagnostics for People Living with HIV/AIDS	http://www.who.int/medicines/areas/access/med_prices_hiv_aids/en/index.html	In partnership with UNAIDS, UNICEF and MSF. Information is included on HIV related medicines including those for opportunistic infections, pain relief for use in palliative care, cancer treatments and for the management of drug dependence and also for diagnostics for initial infection and ongoing monitoring. The report also includes information on the registration status of products and information about registered products per country.
	EC-ACP-WHO Partnership on Pharmaceutical Policies	http://www.who.int/medicines/areas/coordination/ecacpwho_partnership/en/index.html	The Partnership dedicates 25 million Euros to supporting the strategic and technical elements in the development of national essential medicines strategies for countries in the Africa, Caribbean and Pacific Island regions. Technical and financial support is awarded to countries for the following core activities: National medicine police development and monitoring and evaluation; Strengthening of the pharmaceutical system including regulation, financing, procurement and governance and promoting best practices through support to countries, sub-regional groups and regions. The Partnership's key principles include: Focus on country and regional priorities; Promote regional and subregional collaboration; Emphasize a multi-stakeholder approach incorporating civil society; Integrate with other medicines policy projects; Document achievements and impact; Develop global policies, guidelines and tools.
PAHO	Essential Medicines and Biologicals	http://new.paho.org/hq/index.php?option=com_content&task=blogcategory&id=1160&Itemid=1176	The Essential Medicines and Biologicals section of PAHO includes the Pan American Network for Drug Regulatory Harmonization (PANDRH).The network is an initiative of PAHO and national drug regulators which aims to improve regulatory harmonisation. PANDRH includes working groups on Bioequivalence, Combat to Drug Counterfeiting, Drug Classification, Medical Plants, Drug Registration, Drug Promotion, Good Clinical Practices, Good Laboratory Practices, Good Manufacturing Practices, Pharmaco Vigilance, and Pharmacopoeia. Other components are the Steering Committee and the Pan American Conference on Drug Regulatory Harmonization. There is also a Working Group to promote the establishment of Pricing Databases for transparency and referencing in public procurement

AFRO	Essential Medicines Programme	http://www.afro.who.int/en/divisions-a-programmes/dsd/essential-medicines.html	The programme has the following components: Medicine Pricing and Financing: Work includes the AFRO Essential Medicines Price Indicator which contains price information provided by 18 countries and four low cost drug suppliers Medicines Regulation and Quality Assurance Systems: To ensure the quality, safety and efficacy of all pharmaceutical products and to put in place necessary infrastructures and procedures for quality assurance mechanisms. National Medicine Policies: supporting countries to engage in policy dialogue, policy development and analysis, preparation of implementation plans and ensuring the commitment of all stakeholders to national medicine and traditional medicine policies. Procurement and Supply Systems: supporting public procurement and supply agencies to strengthen their capacity and improve efficiency in the procurement and supply management of essential medicines. Rational Use: covering activities such as the development of essential medicines lists linked to standard treatment guidelines for the most common diseases and national medicine formularies.
EMRO	Essential medicines	http://www.emro.who.int/emp/medicines.htm	The four main areas of work include medicines policy, access, quality and safety and rational use. In line with WHO HQ policy, adapted to the regional context.
EURO	Health Technologies and Pharmaceuticals (HTP)	http://www.euro.who.int/pharmaceuticals	The programme operates in three sub-regions: the Newly Independent States (NIS), the south-eastern European countries (SEE), and the European Union (EU) and has a number of elements: Technical support to countries (especially countries in transition) through networks on policies on drug regulation, pricing, reimbursement and rational use builds capacity through training and setting up systems on the regulation, provision and use of medicines in countries; Providing evidence-based tools for implementing pharmaceutical policies, supporting the monitoring of developments in countries and networking among countries and professionals; Working in partnership with the European Union, the World Bank, the United Nations Children's

			Fund (UNICEF), nongovernmental organizations, and academic and professional institutions and networks; Working closely with WHO headquarters, particularly the Essential Medicines Programmes and with the other programmes in the WHO Regional Office for Europe.
SEARO	Essential Drugs & Other Medicines (EDM)	http://www.searo.who.int/EN/Section1243/Section1377/Section1378.htm	The main functions of the programme are: development of national drug policies along with monitoring and revisions; activities around quality, safety and efficacy of essential drugs and vaccines; promotion of traditional medicines and developing and strengthening human resources.
WPRO	Pharmaceuticals	http://www.wpro.who.int/sites/pha/overview.htm	Support is provided for activities which are in line with WHO HQ policy. This includes support for: national medicine strategy development; legislation and regulation; essential drug selection, procurement and distribution; quality assurance; rational drug use strategies and incorporating public health safeguards of the Trade Related Intellectual Property Rights (TRIPS) in to national legislation. WPRO have also published a Regional Access Strategy 2005-2010 which provides guidance to member states and WHO on improving access to quality, affordable essential medicines.
NGOs/ foundations			
SustainAbility	Pharma Futures 2003-2008	http://www.pharmafutures.org/	Initiated in 2004 as a scenario-planning exercise, Pharma Futures is an investor led dialogue which aims to find solutions by examining the link between sustainable pharmaceutical business models and global health outcomes. The three distinct phases of Pharma Futures are: 1) Scenario planning which outlined possible scenarios for the industry. 2) Analysis of the key value drivers for industry and society. 3) Identification of innovative and practical solutions, looking at new business models for commercial success and improved health through structured dialogue between industry, investors, entrepreneurs and global health experts. SustainAbility provided the overall project direction and facilitation
Health Action International (HAI)- Global	General	http://www.haiweb.org/01_about_a.htm	HAI is an NGO with global offices in Amsterdam and regional offices in Africa, Latin America, Europe and Asia. It works as a network of over 200 members including consumer groups, public

			interest NGOs, health care providers, academics, media and individuals in more than 70 countries.
	Medicines Prices, Availability and Price Components 2000-present	http://www.haiweb.org/medicineprices/	This joint project with WHO is based around the production of a manual containing technical guidance and has been developed to allow a standard approach to measuring medicine prices. Governments, civil society groups and others concerned about the prices of medicines are encouraged to undertake a survey using the methodology outlined in the manual. Price information is collected at a sample set of pharmacies in public, private and one other sector which can be defined to fit local conditions. In 2008, the 2nd edition of a manual was published and over 50 surveys are available to view on the database.
	Drug Promotion Database 2002-2003	http://www.drugpromo.info/	This joint project with WHO collects and analyses information on inappropriate drug promotion. A database has been set up with entries sourced from numerous sources including journal articles, books, radio and TV, magazines and many more. The database is the first phase of the project which aims to properly document the information available on inappropriate drug promotion. This will enable interested parties to assess, analyse and learn from it.
HAI Africa	General	http://www.haiafrica.org/	Health Action International (HAI) Africa is a growing regional network of consumers, NGOs, health care providers, academics and individuals in more than 20 countries in Sub-Saharan Africa promoting increased access to essential medicines, the essential medicines concept and the rational use of both modern and traditional medicines. Activities include: monitoring the prices of medicines; undertaking specific research, advocacy and production of publications on access to essential medicines including on stock outs; appropriate use; democratisation of medicines prices
HAI Asia Pacific	General	http://www.haiap.org/	HAI Asia Pacific has three main stated objectives: 1) Reduction of poverty through increased access to and rational use of essential medicines by the poor. 2) Social development through the strengthening the capacity of civil society to demand equitable access to essential drugs through medicines policies that reflect the health needs of citizens. 3) Providing cutting-edge expertise, knowledge and guidance in shaping global, regional and local medicines policies that are results of an inclusive democratic process whereby all stakeholders, including patients and consumers, are involved.

Clinton Foundation HIV/AIDS Initiative (CHAI)	Access Programs 2002-present	http://www.clintonfoundation.org/what-we-do/clinton-hiv-aids-initiative/our-approach/access-programs	CHAI's Access Programs work to lower the price of essential HIV/AIDS drugs and diagnostics, facilitate rapid access to new products, and improve the health and efficiency of the marketplace for these commodities. CHAI's approach uses a pooled procurement approach to enable drugs to be supplied at lower prices. Pricing agreements are signed with generics producers to enable greater access to drugs. CHAI now works in collaboration with UNITAID CHAI is also applying this approach to new areas, including malaria drugs and nutrition commodities.
Access to medicines foundation	Access to Medicines Index 2008-present	http://www.atmindex.org/	The Access to Medicines Foundation is an NGO base in the Netherlands and publishes the Access to Medicines Index. The Index ranks pharmaceutical companies according to their efforts in increasing global access to medicines. The aim is to supply companies, the public, academics, the government and NGOs with reliable and impartial information on pharmaceutical companies while providing companies with a means to assess, monitor and improve their performance. It also creates a platform for stakeholders to share best practices.
Bill and Melinda Gates Foundation (BMGF)		http://www.gatesfoundation.org/Pages/home.aspx	BMGF supports GFATM in supplying drugs for HIV/AIDS and Malaria.
Médecins Sans Frontières (MSF)	General 1970-present	http://www.msf.org.uk/access_to_medicines.focus	MSF advocates for the reduction of the price of medicine on a sustainable basis. Strategies used include encouraging generic competition, voluntary discounts on branded drugs, global procurement, and local production. MSF also supports countries in codifying into law the "safeguards" that are allowed under international trade rules in order to protect access to medicines.
	Access to Essential Medicines Campaign 1999-present	http://www.msfaccess.org/	The campaign was established to improve access to existing medical tools (medicines, diagnostics, vaccines) and to stimulate the development of urgently needed better tools for people in countries where MSF works.
Others			
International Finance Facility for Immunisation (IFFm)	2006- current	http://www.iff-immunisation.org/	IFFm raises money for GAVI. Its strong financial base allows it to have a triple A rating which in turn means that in can raise finance by issuing bonds in the capital markets. This means that long term government pledges can be used to make money available now. The World Bank acts as financial advisor and treasury manager to IFFIm. It is expected that $4 million will be raised for GAVI from the UK, France, Italy, Spain, Sweden, Norway, South Africa and the Netherlands.

Global TB Drug Facility (GDF)	General	http://www.stoptb.org/gdf/	GDF, in addition to it providing TA, quality assurance and capacity building, combines centralized, pooled procurement with a grant-making facility. This arrangement allows it to be able to guarantee a minimum demand to negotiate prices with manufacturers. GDF claims that drug prices have fallen by approximately 30% compared with previous international tenders – to less than US$10 for a 6-8 month course of treatment. The Green Light committee is the procurement arm of the GDF and assesses a programmes suitability to access GDF's reduced prices and provides TA. Major donors to GDF include CIDA, USAID, DFID and UNITAID. GDF is a prequalified source of first line TB drugs and diagnostic equipment for GFATM grants.
NEPAD	NEPAD workshop on harmonisation of drug registration in Africa - February 2009 Johannesburg		NEPAD organised a workshop where project proposals were invited for strengthening harmonisation of regulatory functions at regional economic community (REC) level of Africa. The workshop was funded by DFID and the Bill and Melinda Gates Foundation with technical support from WHO and the Clinton Foundation.

Annex 3: TORs for International Advisory Group

TORs sent to IAG members (compiled by IAG chair and DFID and circulated by Secretariat	Aide Memoire 1st IAG meeting (Written by Secretariat Approved by chair and IAG)	Phase 1 DFID Proposal document DFID (written by DFID)	Website March 2010 (secretariat)
Review findings emerging from MeTA pilot countries and consider their implications to help MeTA to achieve its goals	Analysing, synthesising and providing input at a country level	Provide overall governance and direction for MeTA	Supports the national programmes by reviewing their work
Provide comments on trends within the global pharmaceutical market relevant to MeTA's aims of achieving greater transparency and accountability	Providing counsel and advice to call out key issues, lessons to learn and macro trends that may have an influence on MeTA (to be passed to the Secretariat or to the MeTA Management Board MMB).	Identify issues emerging in the pilot countries that may require action by or support from international partners, including areas where further research would support MeTA goals at national level	Identifying trends in the global market
Make recommendations to the Access to Medicines Research Network on research streams which could improve understanding how access to medicines can be enhanced		Working with national multi-stakeholder groups, will help to shape MeTA as it develops through the course of Phase One and will keep the MeTA model under review	Making recommendations to the MeTA Management Board
Analyse the developments and lessons emerging from MeTA and provide recommendations on the future direction of MeTA in Phase Two.		IAG will draw on lessons from MeTA pilot countries to make recommendations on whether and how MeTA should evolve beyond Phase One.	Analysing lessons learned and suggesting directions for MeTA's second phase, after 2010
Make suggestions on the content of MeTA global meetings			
Analyse the developments and lessons emerging			

from MeTA and provide recommendations on the future direction of MeTA in Phase Two			

Annex 4: Communication Overview

Internal Communication	Processes and Channels	Findings	Recommendation
Within Secretariat	Clear agreed corporate work programme shared	Whilst the Executive Team (H3) has a broad programme there is no communication of the contribution of individuals. This is not routinely shared beyond H3	Formal performance management system desirable together with cascade team briefing
	Individual objectives in place and shared	There is no uniform personal objective setting process nor review.	
	Internal communication systems and protocols	There is extensive use of email and skype/ VOIP. Team meetings every 2 weeks. No standard overall format for feedback and information sharing	
	H3 meetings	No formal cascade of decisions from H3 and minutes not shared widely	
MMB	Regular face to face meetings	Meetings held quarterly. Summary minutes on MeTA website Perception that some major decisions made outside MMB	Important to ensure excellent communication between Alliance partners between meetings
IAG	Three meetings held	Copies of presentations available on website Summary minutes circulated to IAG members Some evidence of feedback to countries	Need to review purpose of IAG and feedback loops with countries
Consultants/ TA	Individual communication with Technical Director	TAs perceive that they lack project wide information and updates on current initiatives	Important to ensure all TAs receive consistent and regular briefing

	Dedicated electronic discussion forum	This is not widely used	
National Level communication			
National Council	Council meetings	Held in all countries. None open to the public Minutes available to members and shared with IMS Peru has separate Executive committee. Minutes are circulated to the wider council and there is agreement they will put on the website	Need to consider how decisions of Councils can be available to all key stakeholders
Country level Secretariat	Email	The smaller secretariats lack basic facilities and capacity for communication. Some do not have dedicated telephone lines and many use hotmail accounts for email	Need to agree basic minimum package for effective operation.
	Reports/ discussion documents	Only Ghana, Jordan, Peru and the Philippines have the capacity to produce reports and discussion documents. Kyrgyzstan has also produced some materials	Need to ensure that councils are clear what decisions they are being asked to take, what options are available and what information is available to inform decision making
	Website	Philippines, Ghana and Peru have established websites Zambia and Kyrgyzstan in design Not all are well maintained or constantly available	Whilst websites make information available to high level stakeholders it is important to check who is using them and for what and adapt accordingly
	Forum	Kyrgyzstan (x1 2008), Ghana (x1 2009) Peru (x1 2008)and the Philippines (x3) have held national forums	Important to have substantive material to demonstrate progress before arranging nation forum
	Newsletters	No Zambia, Philippines, Peru, Kyrgyzstan, ghana Uganda (X1 Sept 09)	Newsletters may give better coverage in country than websites

County level funding bodies	Meetings Briefing papers	Despite the potential for leveraging funding from country level DPs there appears little formalised communication except in Philippines	Need to harmonise with other initiatives as well as national plans. This is also a potential source of additional funding
WHO and WB in country	Meetings Minutes	WHO regular engagement with council in: Uganda, Jordan, Philippines, Zambia WB regular engagement with council in Where WHO or WB do not attend council meetings most appear to receive minutes	Need to consider regular briefing where local WHO and WB reps do not attend meetings
Access to International MeTA information and tools	Website Briefing Country sharing meetings Feedback from IAG Access to tools	The MeTA website had 9,600 visits in 13 months. In this period •MeTA countries accessed as follows Philippines 383 • Peru 377 • Ghana 326 • Jordan 326 8 newsletters have been produced Meeting held in Dec perceived as successful but concerns on quality of interpreters (Spanish) Not systematic in all countries Some tools made available in hard copy or by email	The website is designed primarily for countries yet use is limited. In two countries this is a perceived as a language issue. No budget for translation of materials but also lack of awareness of the translate facility on Google (which is not universally accessible) Consider need for translation Suggest need to focus on specific country successes in detail and analyse the facilitating factors rather than receive general overview feedback Needs urgent attention Suggest need to review usage in countries to inform future

		Communication toolkit available on website	development of tools
International and External			
Global Pharmaceutical Industry	Through IAG Face to face meetings Annual Review Articles	There are representatives of both major pharma and the IFPMA. Not clear what feedback to wider body Major pharma Involved in initial consultation and subsequent meetings with MD Meetings with professional bodies FIP congress Istanbul (09) Commonwealth Pharmacists Assoc conference Ghana (09) Circulated Lancet editorial following Launch	Need to ensure consistent messages between IAG reps and MD
International Level Organisations	Presentations at WHA x2 (08/09) Global Health Council (09) WHO Medicines Seminar (08) TI meeting Athens (08) Targeted material and updates	Used Jordan as example of potential of MeTA No specific evidence found	If future presentations of this sort are planned important to evaluate impact
Potential funders	Meetings Targeted material	DFID currently undertaking exploratory meetings Evaluation report	
Media	Contact with editors and reporters	Editor of Lancet attended launch	Recognise difficulty of promoting

			during pilot phase but need to convey potential
	Press statements	Some countries (Ghana and Philippines) are issuing press statements MOH Peru has issued press statements referring to MeTA. Zambia uses FM radio	Need for training in secretariats beyond the tool kit
	Articles	Lancet report at launch and paper planned for July2010 Articles in Africa Health	
	Film	Promotional film in progress	
Parliamentarians	Invitations to international and country launch	UK Sec of State International Devt attended launch plus parliamentarians from Peru and Ghana	Important to identify major political champions both internationally and in countries.
	Regular updates	Yes Zambia	
	Targeted material	Not identified	
	Meetings	**MeTA Philippines** has 3 members of legislature on council and has regular formal meetings with parliamentarians **MeTA Zambia** council chaired by MP (opposition) and liaison with 5 cross party parliamentarians. Hope to present Motion in Parliament **MeTA Uganda** private sector group has engaged parliamentarian	

Annex 5: Basic competences required for Country MeTA Secretariat

Responsibility	Knowledge	Skills	Attitudes/ behaviours
Servicing the council	Committee procedure	Agenda construction Minute taking Powerpoint Presentation skills	Attention to detail Diplomacy Ability to work to strict time limits
Preparing papers for council	Knowledge of context including technical knowledge Knowledge of sources Knowledge of practice in other countries	Analysis and synthesis Report writing and precis	Ability to work to strict time limits
Performance Management	Knowledge and understanding of activities and multi sectoral context Knowledge of principles of performance management (setting objectives/ appraisal, development)	Appraisal, supervision and personal development skills	Assertiveness Ability to influence without line responsibility
Financial Management	Knowledge of basic accounting Understanding of Forex requirements	Ability to use a spreadsheet or simple accounting package Ability in setting up financial systems (petty cash etc)	Attention to detail
Managing sub contracts	Knowledge of appropriate legal framework	Ability to write “tight” TORs Ability to hold contractor to account	Assertiveness Attention to detail
Communication	Knowledge of stakeholders Knowledge of key messages Knowledge of local media	Ability to use electronic communication (email/ VOIP) Ability to construct/ contribute to	

		websites Ability to write press statements/ speeches etc Ability to use appropriate communication style and content for context	
Logistics	Knowledge of market (travel, hotels etc) Knowledge of visa/ insurance requirements.	Ability to prepare itineraries, briefing material etc	Rigorous desire to achieve value for money
Data Management	Knowledge of sources Knowledge of data gathering, analysis and presentation methodologies	Ability to identify and use appropriate methodologies.	

Annex 6: Bibliography for main report

The majority of literature reviewed came from the countries and is documented in the country study annexes

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Secretariat

Executive Summary, General and Technical Tender and Commercial Tender
MeTA Phase 1 Programme Memorandum (Jan 2008)
MeTA secretariat TORs
Contract document dated 10 October 2008
Contract Amendments 1,2 and 3
Budget amendments 1.2 and 3

World Bank
EFO agreement letter WB/DFID (March 13th 2008)

Contracts re Baseline
TORs MeTA Baseline Assessment Component 2 (MeTA / Harvard Pilgrim Health Drug Policy Research Group)
TORs MeTA Baseline Assessment Component (MeTA/ IDS)

Strategies
MeTA Communication Strategy (undated)
MeTA Private Sector Strategy (Feb 2010)

Reports
Stakeholder Mapping and Communication Audit Design Meeting Sept 2009
Leveling the Playing Field June 2009

Minutes of Meetings
Minutes of all country council Meetings

Minutes and agendas of MeTA Management Board Meetings

MMB Meeting	Date
1	April 2008
2	June 2008
3	June 2008
4	September 2008
5	December 2008
6	February 2009
7	May 2009
8	September 2009
9	November 2009
10	March 2010 (agenda and supporting papers only)

Minutes of MeTA Management Meeting
Fortnightly minutes (incomplete set but indicative)

Annual Programme Report Year 1

Annual Financial Report Year 1

Monthly programme overview
November 2008
December 2008
January 2009
February 2009
March 2009
April/ May 2009

June 2009
July 2009
August 2009
October 2009

Fortnightly update
23rd Oct 2008
9th October 2009

Quarterly reports
Quarter 1 year 1
Quarter 3 year 1
Quarter 1 year 2
Quarter 2 year 2

Team Meeting notes
January 2009
May 2009
October 2009
November 2009

Minutes and Agendas of IAG meetings
September 2008
June 2009
January 2010

Visit Reports (as per country reports)

Additional Survey Documents received from WHO

Pharmaceutical Sector Scan (2009)
Manual Facility survey (2007)
Manual Household Survey (2008)
Survey coordinator checklist
Literature review on MeTA concept

	G	J	K	Pe	Ph	U	Z
Household survey	xD					x	
Pricing survey		x	x	x	x	x	
Facilty survey						x	xD
Assessment Procurement and supply	x				x		
Mapping of partners	x						
Survey Pharmaceutical situation				x			
GGM report		x					

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WHO CCPP (2009) Disclosure Status of Pharmaceutical Sector Data

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