The Medicines Transparency Alliance

Programmatic Review of MeTA Phase II

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The Medicines Transparency Alliance

Programmatic Review of MeTA Phase II

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LIST OF ABBREVIATIONS AND ACRONYMS

ACP	African, Caribbean, Pacific (country group)
APNAC	African Parliamentary Network Against Corruption
CHAT	Coalition for Health Advocacy and Transparency
CSO	Civil Society Organisation
DFID	Department for International Development
EMP	Essential Medicines and Health Products (department)
EU	European Union
GBP	Pound Sterling
GGM	Good Governance for Medicines
HAI	Health Action International
HEPS	Coalition for Health Promotion and Social Development
HQ	Headquarter
IAG	International Advisory Group
IMS	International MeTA Secretariat
KABP	Knowledge, Attitudes, Beliefs and Practices
MDG	Millennium Development Goal
MeTA	Medicines Transparency Alliance
MMB	MeTA Management Board
MOH	Ministry of Health
MRA	Medicines Regulatory Authority
MSH	Management Sciences for Health
NDA	National Drug Authority (Uganda)
NGO	Non-Governmental Organisation
UK	United Kingdom
UN	United Nations
USAID	United States Agency for International Development
VAT	Value Added Tax
WHO	World Health Organization

1 INTRODUCTION

This is the report of a review of the Medicines Transparency Alliance (MeTA) Programme, Phase II. It has been commissioned by the WHO Department of Essential Medicines and Health Products (EMP).

The **Principal Purposes** of the Review are:

1. to provide WHO/EMP with in-depth information with regard to the achievements and challenges of MeTA Phase II
2. to inform WHO strategy for future work in transparency and good governance in the pharmaceutical sector in countries

Objectives

- To determine whether MeTA's objectives were relevant and realistic. The degree to which the project addresses the needs of beneficiaries and other stakeholders.
- To identify key successes/strengths/outcomes of MeTA at global and country level
- To identify barriers/difficulties at global level and in countries when implementing MeTA projects
- To assess achievements in the pharmaceutical sector in Phase II countries - the evaluation criteria should include relevance, efficiency, and effectiveness of the MeTA initiative.
- To document lessons learned and possible catalytic effects of the programme.
- To identify synergies with other programmes/work on good governance and transparency in countries that are relevant and have a potential impact for improving access to medicines
- To assess the degree to which activities were compatible with governmental and stakeholders policies and to what extent those activities are being appropriated and internalized by beneficiaries
- To assess whether the activities were sustainable
- To give recommendations on how lesson learnt from MeTA can best contribute to future WHO work in transparency and good governance in the pharmaceutical sector;

Scope

- Analysis of programme **design** and **implementation**:
- The degree of **coherence** of the programme with national medicines policies and implementation plans at governmental level and activities undertaken by other stakeholders.
- The degree of **co-ordination and complementarities** of project's activities with other donor's activities at country and global levels.
- The prospects for **sustainability** of project benefits. This includes inter alia capacity building, local ownership, and integration of the project's activities into national plans and stakeholders programmes.

Note: See Annex 1 Terms of Reference

Background

Improving access to medicines is a recognised global development priority. The recently agreed United Nations (UN) Sustainable Development Goals include the intent to provide access to affordable medicines and vaccines to all by 2030 (Target 3b). It is also one of the key elements of the goal of Universal Health Coverage adopted by the UN in 2012.

According to WHO more than two billion people lack reliable access to essential medicines in the developing world.[1] Average availability of medicines in public sector facilities in developing countries is just 34%. People are frequently driven to the private sector where availability is higher at 63.2% but prices are often unaffordable.[2]

Moreover, up to 50% of available medicines may be inappropriately dispensed and may also be of poor quality, expired, damaged or fake.

Inefficient public and private markets and poorly functioning supply chains restrict the access of the poor to affordable, quality and appropriate medicines. Lack of information and information asymmetries (e.g. between manufacturers, wholesalers, retailers and consumers) fuel inefficiencies, distort competition, allow corrupt practice, hinder effective management and encourage irrational use of medicines.

[1] WHO (2004). World Medicines Situation Report

[2] MDG Gap Taskforce Report (2008). "Delivering on the Global Partnership for Achieving he Millennium Development Goals"

2 METHODOLOGY

The principal instrument of enquiry for review was based on the set of seven Phase II outputs:

1. Multi-stakeholder forums functioning and approved by governments
2. Capacity built in countries to collect and analyse data
3. Strengthened transparency of the pharmaceutical sector in countries leading to greater accountability
4. Capacities of civil society organisations (CSOs) built
5. Engagement in multi-stakeholder policy dialogue for access to medicines policies
6. Engagement of other relevant actors with MeTA
7. Programme management

The review process comprised the following:

- Initial meeting with relevant staff of the EMP Department at WHO in Geneva
- Desk top review of MeTA documents (work plans, progress reports, meeting reports and minutes, publications, etc.); the list of documents consulted is attached in Annex 5.
- Questionnaire enquiries targeting (a) selected MeTA participants in countries and (b) Health Action International (HAI) and WHO constituting the International MeTA Secretariat (IMS); the questionnaires can be found in Annex 2, and a summary of responses received from MeTA countries in Annex 3.
- De-briefing meeting with staff of the EMP Department at WHO Geneva to present the draft report
- Review of draft and finalization of report

Limitations

The timing of the review did not allow for country visits and the analysis is thus based on written documentation and feedback only.

The main review period coincided with the Christmas period. In addition, MeTA Phase II had nearly ended by that time. As a consequence the response rate to the questionnaires was less than 50%: forty individuals in the seven MeTA countries were contacted and 19 completed questionnaires were received from seven countries. In terms of stakeholder groups five responses were from MeTA coordinators, four from WHO Country Offices, three each from civil society and public sector, two from private sector, and one each from a professional association and from a WHO consultant.

The documentation available for review was voluminous, reflecting actions carried out in the seven programme countries relating to each of the six Outputs during the implementation period of Phase II. However it proved difficult to identify information describing MeTA processes in countries that either favoured or hindered achievement of outputs.

A second difficulty relates to the ability to attribute the achievements in countries solely to the actions taken by the MeTA multi-stakeholder forums. The principal reasons are:

- Many other actors have been working simultaneously on activities aimed at improving national medicines policies and improve the effectiveness of the medicines supply chain. In most if not all participating countries these associated activities have been poorly referenced and there is little evidence that MeTA has actively sought to engage and coordinate with them, for example, by describing how MeTA work plans fit within the bigger picture.

- Participation in MeTA national councils is usually secondary in importance to the principal jobs and responsibilities of its members. They are usually senior figures within their particular sectors. They "wear several hats." Consequently it has often proven difficult to attribute credit in circumstances where individual council members make contributions such as policy advice and recommendations.

3 PROJECT DESIGN

Existing private and public pharmaceutical sector market inefficiencies negatively affect access to quality assured medicines by the poor. The MeTA approach aims to address the related information asymmetries and lack of information with a focus on medicines selection, procurement, prices, availability, quality, promotion and use.

The design of MeTA Phase II builds on the design and experiences of the MeTA pilot, which in turn was inspired by the Extractive Industries Transparency Initiative established in 2002 with strong support from the UK Government through DFID[3].

The MeTA pilot goal was framed in the context of the Millennium Development Goal (MDG) 8 as "To help to operationalise MDG 8 Target 17 to provide access to affordable essential medicines in developing countries in co-operation with pharmaceutical companies". The purpose was "To pilot a new, multi-stakeholder approach towards increasing transparency around the regulation, selection, procurement, sale, and distribution of essential medicines in developing countries, thereby strengthening governance, encouraging responsible business practices and increasing the voice of patients and consumers".[4]

3.1 Intervention logic

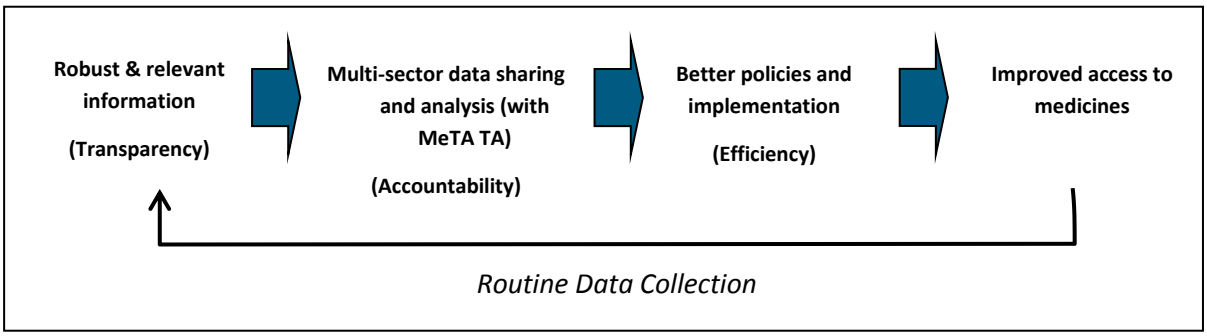
The MeTA pilot evaluation found that multi-stakeholder collaboration was possible and led to more relevant sector information being available, while time had been too short to see relevant progress in data disclosure or contribution to policy or business practice changes.[5] Hence, MeTA Phase II is expected to progress from collecting and sharing data to using this data and the multi-stakeholder dialogue to affect policies and their implementation.

Against this background the overall goal of MeTA Phase II was established as "to increase availability and affordability of quality assured essential medicines in selected countries". The expected outcome is "medicines procurement, pricing, distribution and other policies and practices are changed on the basis of a multi-stakeholder review of robust evidence".

The results chain for the MeTA pilot remained in place for MeTA Phase II. It assumes that (i) the availability of robust & relevant information (transparency), which (ii) is being shared and analysed in a multi-sector/stakeholder setting (accountability) will (iii) lead to better policies and implementation (efficiency), which (iv) will improve access to medicines. Figure 1 shows the results chain as documented in the intervention summary (DFID MeTA Phase II business case).

[3] See: https://eiti.org/eiti/history (accessed 9 December 2015)
[4] MeTA Pilot Phase log frame
[5] Ollier E, Gittins N, Collins T, Mubangizi P, Waddington C, Whitaker D, 2010. Evaluation of the Medicines Transparency Alliance Phase 1 2008-2010. DFID human development resource centre (hdrc)

Figure 1- MeTA Phase II results chain



The DFID business case does not include a Theory of Change[6]. Specific risks and assumptions are included in the programme log frame.

Six outputs were identified for achieving the project's outcome (an additional output relates to external project evaluation and is not further considered here):

- Output 1: Functioning multi-stakeholder groups exist and have national government support
- Output 2: Capacity built in countries to collect and analyse data, using innovative methods as required
- Output 3: Transparency and accountability of the pharmaceutical sector strengthened
- Output 4: Civil Society Organization capacity to support improvements in transparency and accountability of the pharmaceutical sector strengthened
- Output 5: Policy makers in MeTA countries engage in multi stakeholder policy dialogue to develop new or review access to medicines policies
- Output 6: Engagement with MeTA increases

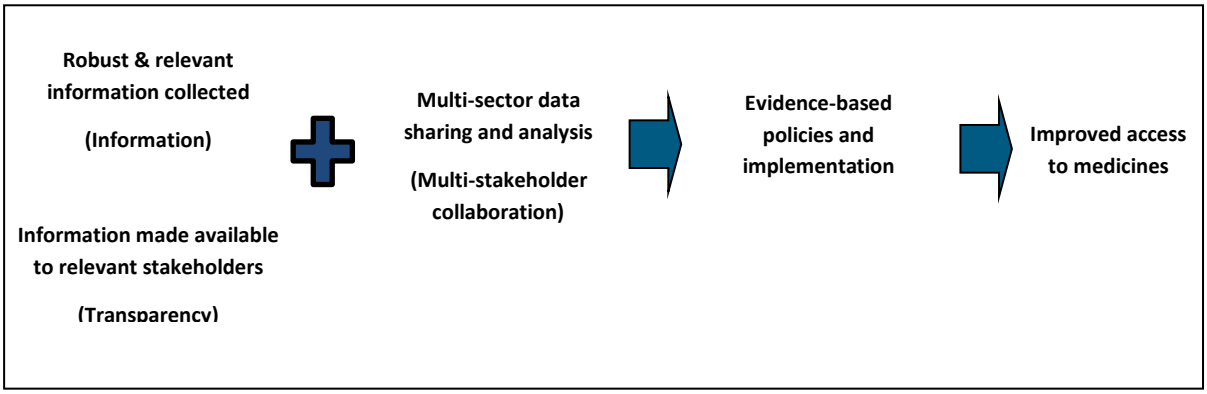
The MeTA pilot had been conceived as a global multi-stakeholder alliance that would be actively guided and assisted by a multi-stakeholder International Advisory Group. The evaluation suggested that the role of the International Advisory Group was not sufficiently clear; that its potential was not effectively utilised; and that related meetings did not provide value for money. However, a big potential was still seen for the International Advisory Group if its work was organised differently. MeTA Phase II does not include a global level multi-stakeholder body and has an overall less formalised approach aiming under Output 6 at increased awareness and preparedness of international (and national) stakeholders to support country work .

Output indicators and targets went through several revisions during the implementation phase in response to findings and recommendations in the DFID annual programme reviews. The aim was to better reflect the realities in each country. These changes improved the specificity, robustness, and outcome orientation of the monitoring framework. At Output level there was a perception that it was beyond the scope of the project to measure changes in accountability. Output 3 was revised accordingly and now reads as "Transparency of the pharmaceutical sector strengthened which leads to greater accountability".

[6] The theoretical evaluation framework presented in the MeTA Phase II external draft evaluation report can be interpreted as a Theory of Change and its testing provides some lessons learnt.

This change is reflected in the MeTA Phase II hypothesis presented in the 2014 Global Meeting Report and reproduced in Figure 2 below, where 'accountability' does not appear any longer as an explicit issue.

Figure 2 - MeTA Phase II hypothesis



3.2 Core principles

MeTA acknowledges that governments are responsible to ensure access of their population to health care, including access to affordable and quality assured medicines. A number of criteria are specified that countries need to meet in order to join and remain a partner of MeTA.[7,8] These include

- Commitment to the MeTA hypotheses
- Commitment of government to implement policies/reforms that enhance transparency and improve access to medicines evidenced by high level political support to MeTA
- Capacity of the Ministry of Health to engage in MeTA, and
- Ability to obtain sustainable funding (the DFID business case clearly states the expectation that additional funding will be secured from other partners to support implementation of country activities)

The administrative guidance for development of country work plans notes that the following principles should be adhered to[9]

- Alignment with the MeTA global log frame
- Country owned and country driven
- Responding to national context, needs, priorities and policy objectives
- Be harmonised/integrated with national structures and development priorities

In the project documentation there is no explicit reference to a MeTA focus on / or expected contribution to health systems strengthening. However, the DFID business case notes that MeTA should be conceived as a catalytic project that has been designed "to add value to broader investments in pharmaceutical and health systems". In addition, potential indirect benefits are mentioned that would contribute to health systems strengthening, e.g. better medicines availability

[7] MeTA. Entry to the Medicines Transparency Alliance initiative: criteria and procedure
[8] MeTA. Medicines Transparency Alliance: Criteria and procedure for exit from the alliance. Version 1.1
[9] MeTA. Administrative and budgetary guidance for submission of MeTA country work plans. Version 1.1

would lead to increased health services utilisation; efficiency gains and cost containment would contribute to sustainable health financing and universal access.

3.3 Country selection

It was foreseen that all seven countries from the MeTA pilot phase would continue receiving support under MeTA Phase II, allowing them to consolidate progress and further proceed towards the MeTA goal.

The intervention summary states that the funding envelope of GBP 6 million should be flexible to allow for the possible inclusion of new countries that met the entry criteria. We were informed that this was regarded as unrealistic given the budget reductions compared with the Pilot Phase.

3.4 International programme management

The DFID business case established as the most favourable option for international programme management the partnership of HAI/WHO in which administrative and civil society capacity building tasks would be the responsibility of HAI, and technical assistance to MeTA Councils and related technical tasks the responsibility of the WHO EMP Department. The DFID Business Case noted apparent limited experience on the part of HAI and WHO of working with the private sector. This was anticipated to be addressed by requiring the partners to submit proposals on how to ensure private sector engagement in MeTA.

We take note that the chosen option is not in line with one of the criteria recommended in the MeTA pilot evaluation, i.e. that international programme management should best be established at one single organisation. This recommendation aimed to address some of the management and communication shortcomings that were related to the set-up of the International MeTA Secretariat during the pilot as a 3-partner consortium with different physical locations.

4 CONTEXT

4.1 Origins of MeTA

Improving access to essential medicines has long been the focus of many international development programmes and projects focusing mainly on developing countries.

However, very few health programmes have given high priority to improving transparency and governance within the health system and specifically the pharmaceutical sector. Apart from MeTA these include the programme on governance led by Management Sciences for Health (MSH), the WHO Good Governance in Medicines (GGM) programme and the ACP/EU/WHO Renewed Partnership for Pharmaceutical Systems Strengthening.

MeTA evolved from earlier experiences in Africa that were supported by the United Kingdom (UK) Department for International Development (DFID) and involved WHO. The programme was initiated, designed and funded by the UK DFID. It was stimulated by growing interest in the roles of transparency and good governance.

MeTA's underlying hypothesis, by which collection and sharing of data amongst key stakeholders improves transparency and influences policy and business practice, draws upon DFID's Extractive Industries Transparency Initiative.

Collaboration with WHO in the area of transparency is said to have included the Good Governance in Medicines (GGM) programme and a joint statement to this effect was issued in 2008. Whilst MeTA's primary objective was to be disclosure of information and multi-stakeholder collaboration, GGM's emphasis was on strengthening government and regulation procedures and on promoting a culture of ethical practice.[10]

Jordan, Philippines and Zambia were common to both MeTA and GGM. The pilot evaluation found evidence of limited collaboration in Jordan.

Despite an initial intention to attract other partners, DFID has remained the sole funding source although WHO has provided additional staff and financial resources as part of its wider activities both in MeTA countries and globally.

Implementation of the MeTA Programme has comprised a Pilot Phase (Phase I) from 2008 to 2010 and a Phase II from 2011 to 2015.

4.2 Pilot Phase

The MeTA programme formally commenced with a Pilot Phase which took place between May 2008 and December 2012.

Seven countries were selected to participate, all continuing into Phase 2. Selection criteria are said to have been rather ad hoc. Initially it was intended to include one country per WHO Region. Finally there are two in the African Region and none in South-East Asia Region. (Ref: Pilot Evaluation).

[10] WHO, 2014. Good governance for medicines: model framework, updated version 2014. Geneva: World Health Organization

In line with the unique features of the MeTA model, the **rationale** was that a complex ground-breaking programme would require a period of learning-by-doing in which participating countries would move forward with the assistance of common guidelines and planning frameworks. Lessons learned would lead to adjustments, build credibility and momentum. This in turn would attract interest in collaboration on the part of more countries as well as development partners and funders. Thus MeTA was perceived both as experimental (based on a hypothesis) and as a catalyst. This phase was heavily focused on process (Pilot Evaluation).

The programme principles emphasised country leadership and country specificity. This was to be ensured through a strong emphasis on an initial country situation analysis which would then form the basis for dialogue between members of the country MeTA multi-stakeholder forums (Councils) leading to country-specific work plans.

At the same time, however, strong leadership and guidance from the global level were put in place in order to a) ensure compliance with technical norms, guidelines, norms and processes related to collecting and sharing information b) facilitate comparison and lessons learnt and c) ensure managerial oversight and accountability for funds.

The structures created at global level comprised an International Secretariat, a Management Board (MMB) and an International Advisory Group (IAG). World Bank and WHO were members of both MMB and IAG. This structure attracted some adverse criticism during the subsequent Pilot evaluation since it appeared to favour a top-down approach.

The Pilot Evaluation structured its analyses according to the principal MeTA outputs. In summary the programme was judged to have made a very promising start. Findings, conclusions and lessons learnt are too numerous to be listed here. Most importantly all countries had successfully established a multi-stakeholder council which had completed a situation analysis as the basis for subsequent planning and policy dialogue. The evaluation also noted examples of policy changes in some countries such as Jordan, Kyrgyzstan and Philippines, that were seen as MeTA's potential to achieve change in the longer term. (Ref: Pilot evaluation report).

The evaluation also noted the effectiveness of intercountry learning events and capacity building activities at international level.

The evaluation also made some critical observations, including:

- No evidence of change in business practice on the part of the private sector stakeholders. Whilst the principles of the MeTA model were appropriate, a particular problem was lack of definable output with regard to private sector participation.
- High transaction costs that did not deliver particular benefits
- National Councils did not demonstrate best practice with regard to good governance. For example, members should sign conflict of interest declarations.
- Undue imbalance in budget allocation favouring the global level. The report cited a high level of expenditure on IAG activities.
- Non-compliance with the Paris Principles of good development cooperation practice with regard to lack of integration within country-specific planning frameworks
- Poor performance by the-then IMS, especially its leadership and communications functions

The findings of the evaluation report provoked a review of arrangements for Phase II. In particular a new IMS was established, comprising HAI and WHO, and the annual financial provision was reduced (see Chapter 6).

There was a period of about one year with no funding. Together with a reduced budget for Phase II resulted in a delay implementation until August 2011. During the intervening 10 months most countries encountered disruption of Council activities including loss of members, changes in Council secretariats and loss of momentum.

5 OPERATION OF META IN COUNTRIES

This chapter summarises progress in the six MeTA Phase II output areas relevant for country work. Progress has been monitored and reported on in detail since 2012 in the IMS and DFID Annual Review reports. The latest DFID Annual Review of 2015 found that performance in the six output areas was at least according to expectation, meeting the established end of project indicators and milestones. In line with the overall purpose and objectives of this Programmatic Review we will focus on context and processes relevant for achieving the outputs.

5.1 Multi-stakeholder collaboration (Output 1)

The set-up of the MeTA structures in each country is documented in Table 1. MeTA councils in all countries have representation from public and private sectors, civil society; academia and professional organisations are represented in selected countries only. The exact composition of the councils is not easy to establish. For example, the MeTA international website only presents the composition of the councils from the pilot phase and where they exist, country websites were not all accessible.[11] Anticipated council compositions can be found in the narrative country work plans, but these were in most cases not yet final. Available lists of council members do not always include the position of the individual member within the stakeholder organisation s/he represents. The information presented in Table 1 is thus derived from a variety of sources.[12] It should also be noted that the set-up (e.g. council members, composition and locations of MeTA Secretariat, or council meeting venues) was subject to changes during the time of project implementation.

Table 1 - MeTA set-up in countries

Ghana	MeTA is registered as legal entity MeTA Council: 19 members; decision making body; quarterly meetings; Chairs: Ministry of Health & private not-for-profit sector; meetings held at WHO County Office (free meeting rooms) Sub-commissions/working groups established Secretariat at WHO Country Office; 1 coordinator & 1 administrative staff CSO coalition: NGOs in Health
Jordan	MeTA Advisory Board: 5 members (multi-sectorial); headed by Minister of Health; annual meetings; oversees implementation; minutes publicly available (website); MeTA Steering Committee: 14 members; operational decision making body; Chair: Director MRA; monthly meetings; coordination, planning, management; minutes publicly available; meetings held at MRA (free meeting rooms) Sub-commissions/working groups established Secretariat at MRA (free office); 1 coordinator CSO coalition: Jordanian CSO Health Alliance
Kyrgyzstan	MeTA Council: 18 members; decision making body; internal rules; bi-annual meetings; Chair: senior academic; meeting facilities provided for free at MOH; Sub-commissions/working groups established Secretariat is provided with free meeting space at MOH; 1 coordinator, 1 technical assistant and 1 WHO representative CSO coalition: Alliance for Transparency in Drug Supply

[11] MeTA websites for Jordan and Kyrgyzstan could not be assessed (in Arabic and Russian respectively). Website for MeTA Ghana was not reachable until 18 January 2016, and the web domain for MeTA Philippines seems to be 'for sale'.

[12] For example, country progress reports (mainly on Output 1.2), MeTA country websites; council meeting minutes; IMS progress reports to DFID; DFID Annual Reviews; report of the 2014 Global Meeting.

Peru	MeTA is a registered entity MeTA Assembly (Council): 15 members; decision making body; internal rules; meetings every 2 weeks; minutes publicly available (website); Chair: Director MRA; free meeting venue provided by council member organisations (rotational basis) Sub-commissions/working groups established; Secretariat at MRA (free office); 1 coordinator, MeTA council chair, WHO staff CSO Coalition: NGOs in Health
Philippines	MeTA is registered as legal entity; annual membership fees MeTA Council: decision making body; quarterly meetings; MeTA Board of Trustees: 15 members; elected by & reporting to council; executive function; bi-monthly meetings Secretariat at rented premises; 1 coordinator and Board chair CSO Coalition: Coalition for Health Advocacy and Transparency (CHAT)
Uganda	MeTA Council: 12 members; decision making body; internal rules; bimonthly meetings; rotating chair (public, private, CSO); free meeting room provided at WHO Country Office; as from Year 4: plans to change venue to MOH. Secretariat at MRA (free office); 1 coordinator plus 3 council members (1d/week) CSO Coalition: Coalition for health promotion and social development (HEPS) and Uganda National Health Consumers Organisation
Zambia	MeTA Council: 15 members; annual meetings at hired venue; some minutes publicly available (website); Chair: Representative of African Parliamentary Network Against Corruption(APNAC)[13]; MeTA Executive Committee: 5 members including Secretary General elected by council; executive decision making body; office provided by Pharmaceutical Society of Zambia Sub-commissions/working groups established; Secretariat: 1 coordinator CSO Coalition: CSO Coalition for Transparency in Medicines

MOH: Ministry of Health; MRA: Medicines Regulatory Authority;

The draft report of the MeTA Phase II evaluation noted that the MeTA council in Kyrgyzstan consists of senior and well-known representatives, which interviewees noted as a reason for the general credibility of the multi-stakeholder platform.

The processes for how membership of the councils was established are not explicitly stated in the documents that were available for review. From IMS and country progress reports it appears that in most cases at least some of the council members from the MeTA pilot phase initially worked on preparations for Phase II. The IMS assisted in adapting governance structure and leadership for example in Ghana, Jordan and Peru considering lessons from the pilot phase, stakeholder capacity and legitimacy. IMS did not implement specific capacity building activities for how to work, build trust and address conflicts in a multi stakeholder environment. In Uganda the IMS supported the process of ensuring government commitment. In general, there was no requirement for government to formally commit in writing to the MeTA principles and the project.

Internal rules and specific Terms of Reference guiding the work of the MeTA councils are mentioned in project related documents for the majority of MeTA countries. However, these rules are neither publicly accessible (e.g. on the national or international MeTA websites)[14] nor were copies available to the review team. Examples for internal rules from the pilot phase suggest that in at least Jordan,

[13] The Chair is also a Member of Parliament, which provides relevant expertise and probably facilitates access to policy makers for MeTA Zambia.

[14] MeTA websites for Jordan and Kyrgyzstan could not be assessed (in Arabic and Russian respectively). Website for MeTA Ghana was not reachable until 18 January 2016, and the web domain for MeTA Philippines seems to be 'for sale'.

the Philippines and Zambia changes related to MeTA governance were made in MeTA Phase II. Except for Zambia the MeTA council (or equivalent) is the decision making body. In Zambia this function has been delegated to the elected five-member MeTA Executive Committee with representation from all stakeholder groups.

Feedback from questionnaires indicated that participation of the represented stakeholder groups was not uniform: weak participation and/or underrepresentation were reported for each of the three stakeholder groups as a challenge by at least one respondent. Irregular attention of meetings by council members was one of the problems identified which is in line with findings from the 2014 Global MeTA Meeting. Reasons mentioned were the in general busy schedules of council members, and the voluntary nature of work, including lack of financial incentives to attend meetings. On the other hand, all 19 respondents stated that the members of each group contributed effectively to the discussions and work programme. For Ghana and Zambia it has been reported that a persistent challenge was to reach a quorum at meetings.

Examples for conflicts arising within councils or with certain stakeholder groups were provided by respondents and in country progress reports: in some instances the private sector resisted proposed changes; not all relevant stakeholders actively participated (examples included MRA, national medicines procurement and supply agency, local industry); conflict of interest was not always openly declared and managed; distrust and different positions within the private sector group led to postponement of planned activities. Successful strategies for resolving conflicts were willingness to compromise and to change initial positions, and persistent discussions and dialogue. Participants at the 2014 Global Meeting concluded that it was crucial to be inclusive of key stakeholders; open to the view of others; openly declare interests; have clear criteria for representation; and identify champions/opinion leaders for each stakeholder group. Stronger commitment of government was noted as a requirement for increased commitment of the other stakeholder groups. Turn-over of key government stakeholders participating in or supporting MeTA was identified as a risk and on-going challenge.

All MeTA councils developed work plans approved by the IMS, although the process was longer than expected. Technical support and transition funding was provided by IMS and WHO country offices to (re-)establish MeTA councils and for development of work plans. The IMS had provided criteria for the process and principles for work plans against which drafts were assessed. Examples for criteria are: developed in multi-stakeholder setting, being peer-reviewed; responding to national needs / aligned with policy objectives, and addressing the core issues of MeTA. The narrative work plans provide the broader country context and challenges with regard to access to medicines. Most of the work plans state to be informed by findings from the MeTA pilot phase. In addition, reference is made to relevant national policies and priorities identified in health sector strategic plans, but it is not made clear how MeTA work plans are aligned with sector plans and support provided by cooperating partners. It can be assumed that through participation of public sector stakeholders government priorities were addressed.

All countries organise (annual) national MeTA Forum meetings, with a larger number of stakeholders from the different constituencies. Zambia notes the opportunity to convert the MeTA Forum to the MeTA General Assembly that would eventually elect the MeTA Council. Uganda used the 2014 Forum to present and discuss all studies done under MeTA Phase II with a group of 70 stakeholders.

All seven countries have established MeTA Secretariats, with at least one (part-time) coordinator funded under the project. The availability of a coordinator was found decisive to progress with implementation of work plans. It was favourable if the coordinator had relevant technical expertise in addition to administrative skills. Role and responsibilities of the Secretariats are quite uniform and include programme administration and coordination; communication with council members and working groups; drafting of work plans; technical & financial reporting; communication with IMS; organisation of meetings; information dissemination; website management; and approval of expenditure.

5.2 Building capacity in countries to collect and analyse data (Output 2)

By Year 3 (2014) all countries engaging in data collection/surveys were expected to have produced at least one analytical report deemed satisfactory by WHO and by Year 4 (2015) were expected to have used the evidence generated to make policy recommendations or interventions addressing access to medicines. According to the DFID Annual Reviews these milestones and the output indicator were achieved by mid-2015. Table 2 provides a list of reports produced during MeTA Phase II up to June 2015.

Table 2 – Examples for achievements in data collection & analysis

Ghana	Needs assessment for monitoring medicines availability & price using new approach for data collection Medicines price & availability survey (on-going?) Baseline study on Drug & Therapeutics Committees & Rational Use of Medicines (2015) Assessment of Knowledge Attitude Beliefs and Practices of health-related CSOs on Access to Medicines, Transparency, Accountability and Good Governance (2014) Value Added Tax (VAT) exemption review & related ABC/VEN analysis
Jordan	Desk research feeding into national policies (medicines, pharmacy & therapeutics committees, disclosure, essential medicines); policies & reports published on website Needs assessment for monitoring medicines availability & price using new approach for data collection Health facility survey (funded by Canada)
Kyrgyzstan	Review of available documentation as basis for development of National Medicines Policy; Development of monitoring system for National Medicines Policy; Development of tool for pharmaceutical sector reporting system (implementation delayed due to changes at senior MOH level); Assessment of drug regulation impact on promotion practices; Review of medicines regulation vulnerability to corruption – recommendations made to MOH; Development of drug codifier software facilitating monitoring of prices, e- procurement and others; Needs assessment for monitoring medicines availability & price using new approach for data collection; Mapping developing partners activities related to antibiotic resistance
Peru[15]	Re-design of price observatory; Development of quality and availability observatories Monthly median sales price reports (up to 03/2015 available on price observatory website) 3 analytical reports using data from price, quality and availability observatories are on-going (1 draft report available as per 18 August 2015 minutes)

[15] For Peru progress reports list the production of five analytical reports using data from the medicines price observatory. However, the link provided leads to reports published in 2010 and 2011 (before the start of MeTA Phase II) which are therefore not included in this list.

Philippines	Mapping of medicines entitlement programmes of the national government; CSO monitoring tools for 'Medicines Watch' and 'Philihealth Watch' programmes Pilot of the HAI / MeTA Tool Medicines promotion: assessing the nature, extent and impact of regulation in the Philippines; Stakeholder Mapping and Development of a Framework for the Engagement and Empowerment of Patient Organisations in the Philippines (2014)
Uganda	Medicines price component study; Medicines availability and pricing surveys; Screening drug quality report; Client satisfaction survey; Assessment of functioning of hospital Medicines Therapeutics Committees
Zambia	Report on public procurement practices and its effect on local manufacturers (draft?) Medicines price & availability survey (by December 2015 data collection was yet to start)

WHO technically supported this output by reviewing Terms of References, study protocols, and draft reports. WHO country office staff sitting on the MeTA councils also provided on-going technical advice as documented in council meeting minutes. WHO/HAI tools were used for medicines price and availability surveys and HAI tools for assessment of medicines promotion. The IMS also funded participation of selected MeTA members in pharmaco-economics and pharmaceutical policy training courses. It is not quite clear though, how the need for these specific trainings was identified and what the impact was.

Respondents to the questionnaire noted technical capacity building support from both, HAI and WHO. One respondent stated that technical work could only start in earnest once the MeTA focal person had been appointed at the WHO country office and in general more technical support (e.g. training, tools) for the sub-committees / working groups would have been appreciated. While Zambia initially had an approach to use information generated and collected during the MeTA Pilot Phase the 2015 IMS progress report noted that lack of capacity to plan, budget and manage was one reason that the intended medicines price and availability survey was not implemented on time.[16]

Building capacity through sharing of experiences and collaboration between MeTA countries does not seem to have been supported comprehensively. Questionnaire respondents noted that the 2014 Global Meeting was useful but came too late, and that IMS should have done more to promote exchange of experiences (e.g. a formal platform, exchange visits). Two positive examples were mentioned (e.g. a teleconference between Jordan and Kyrgyzstan on policy review), but these seemed to have been rather ad-hoc activities. Several respondents pointed out that IMS shared experiences from other MeTA countries during country visits, which was felt to be very useful.

Annual progress reports of IMS to DFID include plans for webinars and technical dialogue series, but only one event was organised for Jordan and Kyrgyzstan. Technological, language and time zone challenges prevented implementation of the dialogue series. It is also reported that WHO staff shares examples of study protocols and reports via e-mail.

MeTA Councils usually established specific working groups to implement data collection, analysis and reporting under Output 2. Studies are mostly contracted to local consultants. There is no common way on how the working groups or technical committees are established. For example, in Uganda, the guideline is that at least one member of each of the three stakeholder groups needs to be

[16] N.B. MeTA Zambia attributed the delay on conducting the planned survey to a delay in release of funding from the WHO Country Office.

member of each working group, while feedback from the Philippines noted that the three sectors are working on different subjects. In Kyrgyzstan MeTA works through multi-stakeholder expert groups and inter-sectoral working groups appointed by the Ministry of Health, in addition to MeTA internal working groups. MeTA also advised the Ministry of Health on the composition of the inter-sectoral working groups.

5.3 Strengthened transparency of the pharmaceutical sector leading to greater accountability (Output 3)

The formulation of Output 3 assumes that increased transparency leads to greater accountability. We did not find definitions for either transparency or accountability in the MeTA project documents or on the global MeTA website. Definitions used by Transparency International are reproduced in the text box.[17] Some discussions on multi-stakeholders initiatives question that technical transparency (e.g. reports, website publishing) is sufficient to improve accountability, and point to the complex power dynamics and political incentives related to government accountability.[18,19]

Transparency is a characteristic of governments, companies, organisations and individuals that are open in the clear disclosure of information, rules, plans, processes and actions.

Accountability is the concept that individuals, agencies and organisations (public, private and civil society) are held responsible for reporting their activities and executing their powers properly. It also includes the responsibility for money or other entrusted property.

The milestones for Output 3 focus on dissemination of information and findings from data collection and reports to stakeholders and the public, and the target is that relevant information is made transparent and informs advocacy. Countries used a number of methods for dissemination of information. These are summarised in Table 3.

Table 3 – Methods for dissemination of information

	Ghana	Jordan	Kyrgyzstan	Peru	Philippines	Uganda	Zambia	Total
MeTA country website	√		√	√	For a limited time only		√	**4**
MeTA Facebook/twitter	√				√	√	√	**4**
Videos through you tube					√		√	**2**
(Electronic) newsletter	√					√		**2**
Dissemination via e-mail		√	√		√	√		**4**
Distribution of hard copies		√					√	**2**
Government websites (including MRA)		√	√	√				**3**
Partner & Media websites			√			√		**2**

[17] See: https://www.transparency.org/glossary/term/transparency and https://www.transparency.org/glossary/term/accountability - accessed 02/01/2016

[18] Halloran B. 2015. From openness to real accountability: the role of MSIs. Transparency Accountability Initiative. http://www.transparency-initiative.org/think-pieces/openness-to-accountability-role-of-msis

[19] Fox, Jonathan. 2007. The uncertain relationship between transparency and accountability. Development in Practice, 17:4, 663 - 671. http://escholarship.org/uc/item/8c25c3z4#page-2

	Ghana	Jordan	Kyrgyzstan	Peru	Philippines	Uganda	Zambia	Total
MeTA multi-stakeholder forum	√	?	√	√	√	√	√	**6**
Round table discussions / discussion series / focus group meetings			√	√	√	√	√	**5**
Presentation at non-MeTA events					√			**1**
Media reports of events	√		√	√	√	√	√	**6**
Radio shows							√	**1**
Workshops		√		√	√		√	**4**

Some documents are also made available on the WHO essential medicines and health products information portal, and the WHO EMP MeTA project website.

Jordan and Kyrgyzstan reported as one method for dissemination of information discussion of reports within the MeTA council. While this makes information available to the different stakeholder groups it does not guarantee per se that the larger constituencies will benefit. Respondents to the questionnaire stated that council members usually 'try their best' to provide feedback to their constituencies. However, there were also examples provided where this feedback seems to be less effective (e.g. where the private sector was not well organised) and information does not always reach decision makers. We noted that respondents from the different stakeholder groups usually only knew how information was disseminated within their specific constituency. From this we conclude that MeTA councils did not systematically discuss and follow up on this important topic.

MeTA Uganda contracted a communications consultant serving as contact point for the media and producing communication material, and MeTA Zambia had a media specialist as council member.

MeTA Philippines developed a communication strategy, and produced a comprehensive dissemination plan providing details on information source, target audience, dissemination method, purpose, key messages and results/impact of dissemination. This might have been done responding to a request of the IMS to all countries. It is not known whether similar dissemination plans have been produced by the other MeTA countries and whether this information was used to retrospectively assess the effectiveness or appropriateness of the different dissemination methods.

The DFID 2013 Annual Review recommended that a paper should be produced summarising dissemination strategies and successes in the MeTA countries. The related IMS draft paper provides examples for the diverse approaches in countries and notes that success of communication has not been measured methodologically, but provides examples for successes, i.e. improved transparency through making considerable additional information available on the MRA website (Jordan); increased support of targeted stakeholder groups (Kyrgyzstan); and provision of additional funding from partner agencies (Uganda).[20] The success in Jordan has been facilitated by the disclosure policy developed with MeTA support and accepted by government.

In terms of processes and impact the MeTA Phase II Draft Evaluation Report found that

[20] 2014. Outline of key messages, audiences and dissemination methods for MeTA countries – Draft (to be completed)

- In Kyrgyzstan MeTA did not have guidelines for information sharing, but minutes of MeTA meetings were consistently shared. Interviewees felt that MeTA contributed to the fact that the MRA website provides more (though still inadequate) information. The evaluators feel that the 'drug codifier' being developed with MeTA support has great potential to improve transparency in pharmaceutical procurement.
- In Uganda MeTA contributed to more transparency in the area of quality of medicines through facilitation of information sharing among members and other stakeholders. MeTA attempted to sign an information sharing agreement with the MRA but was not successful. The national medicines register is now available on the MRA website but information on products with inadequate quality is not being made publicly available.

Questionnaire respondents from Zambia unanimously stated that dissemination of information was very effective to create awareness in the general public about quality of medicines and their right to essential medicines and health in general.

All in all it can be concluded that dissemination of information in the various forms contributed to access to medicines policy changes, but evidence that increased transparency led to governments being held accountable is still scarce. WHO has commissioned a specific piece of research on this topic.

5.4 Building capacity of Civil Society Organizations to support improvements in transparency and accountability (Output 4)

Civil Society Organisations are generally considered to be the stakeholder group with least capacity (e.g. technical expertise; advocacy skills and voice to effectively engage in multi-stakeholder policy dialogue) and most difficulties to be accepted as an equal partner at the table. Even within a particular sector, such as health, CSOs are often fragmented, addressing very specific concerns or covering limited geographical areas, which affects their opportunities to engage in more strategic health policy dialogue. This was acknowledged during the MeTA Pilot Phase which included a specific CSO capacity building component with a separate budget supposed to be implemented at country level by a coalition of CSOs.

In MeTA Phase II funds for Output 4 were to be drawn from the budget managed by HAI. This provided for annual amounts of approximately GBP 40,000 for each country to cover "administrative/content and civil society capacity building" expenses[21]. The specific milestones and targets for Output 4 were defined by each country taking into consideration the wide variations in CSO capacity between countries. Table 4 provides key information on MeTA associated CSOs and examples for capacity building activities that were conducted.

Table 4 – CSO capacity building

Ghana	Ghana Coalition of NGOs in Health representing 400 NGOs is partner of MeTA Ghana Assessment done of Knowledge, Attitudes, Beliefs & Practices (KABP) of CSOs to identify capacity gaps; Training manual based on KABP study was developed; implementation delayed

[21] MeTA. Administrative and budgetary guidance for submission of MeTA country work plans (V 1.1)

Jordan	Jordanian CSO Health Alliance (30 members) is MeTA partner; MeTA established advocacy committee to guide advocacy work & organised advocacy meetings between CSO and stakeholders; MeTA established forum for patient groups; training workshops for CSO coalition on advocacy and patients' rights; CSO represented in MeTA technical committees and in Parliamentary Health Committee working on medicines legislation; CSO invited to participate in Government Health Strategy
Kyrgyzstan	CSO is fund holder; CSO Coalition (19 members) is MeTA partner; Development of training curriculum and training of Community Based Organisations on monitoring of public procurement; public awareness campaigns directed at key representatives of civil society and local NGOs (e.g. on falsified medicines through round tables at community level; on benefit packages; on right to access to quality assured medicines; on antibiotics use); forum on medicines for local authorities
Peru	CSO is fund holder; Training of CSOs for & implementation of surveillance system for monitoring availability of priority medicines; Meetings on drug policy dialogue
Philippines	CSO Coalition for Health Advocacy and Transparency (CHAT) is MeTA partner; CHAT workshop series for capacity building (e.g. Trans-Pacific Partnership Agreement; Theory of Change; community monitoring) CSO monitoring of medicines availability & minimum benefits package: tool development, CSO training, pilot surveys;
Uganda	CSO is fund holder (Coalition for Health Promotion and Social Development/HEPS); CSO coalition: Uganda Coalition on Access to Essential Medicines is MeTA partner; CSO empowerment training at district level; CSOs became partner in social accountability projects funded by other partners 'inspired' by MeTA CSO accountability work; this increased financial capacity
Zambia	CSO is fund holder (pharmaceutical society)[22] CSO Coalition for Transparency in Medicines is MeTA partner & meets monthly; Establishment of CSO focus groups (including Facebook pages) at district level including general training (organisation of meetings etc.) & training in social media;

Additional capacity building support funded by the IMS included sponsoring of CSO participation in the Utrecht University Summer School on Pharmaceutical Policy (Uganda & Kyrgyzstan / 2015), and provision of advocacy and social media training courses at district level (Zambia / 2015). One global meeting specifically for CSOs was held in Amsterdam in 2014 attended by CSOs of six of the seven countries. A second meeting had been planned for 2015 but was finally not conducted. One civil society representative each from Ghana, Uganda, and Zambia was sponsored to participate in the in International Peoples Health University and the Peoples Health Assembly in Cape Town in 2012. All three participants later continued as members of the MeTA councils.

Changes regarding the roles and position of CSOs in the multi-stakeholder processes are documented in Table 5. Information is based on IMS initial country assessments and progress reports, and the MeTA Phase II Draft Evaluation Report, which provided specific case studies for Kyrgyzstan, Uganda and Zambia. It should be noted that the initial assessments of CSO capacity were the result of scoping visits and not based on the application of a comprehensive and uniform assessment tool.

[22] Drawing on experiences during the MeTA Pilot professional organisations and academia should rather be seen as a 4th stakeholder category, as they represent their peers rather than broader civil society. In some reports the Pharmaceutical Society of Zambia was labelled 'independent'.

Table 5 – Evolvement of CSO capacity during MeTA Phase II

	Status at IMS scoping visits (2011/12)	Status at end of project (mid 2015)
Ghana	CSO weakest stakeholder group; unsuitable representative on council (conflict of interest); replaced by representative from NGOs for Health Coalition	Has formalised civil society coalition with elected coordinator; Mistrust of CSOs within MeTA delayed implementation of capacity building plan
Jordan	Strong and well organised CSO coalition (resulting from MeTA Pilot Phase)	Has formalised civil society coalition with elected coordinator; CSO chairing e.g. committee on National Drug Policy, but still struggling to become a fully accepted partner;
Kyrgyzstan	CSO sector particularly strong & MeTA Pilot Phase has contributed to this; CSO representation in MeTA concentrated in one organisation.	Has formalised civil society coalition with elected coordinator; Exceeded expectations regarding implementation of Output 4 work plan; More weight given to CSOs opinions & policy makers seek CSO inputs but also attempts to silence/discredit CSOs; MRA considers CSOs as amateurs and their involvement is not welcome
Peru	Strong but fragmented CSO sector	Institutionalised CSO voice in policy dialogue
Philippines	Strong CSO coalition	Has formalised civil society coalition (CHAT) with elected coordinator; Exceeded expectations regarding implementation of Output 4 work plan; CHAT able to analyse available information & communicate public view for health sector planning
Uganda	CSO coalition has mandate of council to provide MeTA Secretariat, but is fragmented and interest in MeTA diminished	Has formalised civil society coalition with elected coordinator; Has shifted approach for engaging with public sector from activism to advocacy; has voice, access & trust to engage with government
Zambia	One strong CSO (Transparency International Zambia Chapter) driving process; other CSOs rather marginalised and isolated	Has formalised civil society coalition with elected coordinator; Capacity built of CSOs locally (district level); Relationship with government improved but remains ambivalent

Overall it appears that CSO capacity to engage in and address access to medicines related issues has been strengthened during MeTA Phase II. Evidence includes Civil Society Coalitions working on access to medicines, transparency and accountability that have been established in 6 of the 7 countries (some during the pilot phase). This ensures that the CSO sector can function effectively as a stakeholder group in the MeTA processes. For many of their member organisations the specific field of access to medicines was new, and workshops and awareness campaigns aimed at increasing technical capacity in this area. Respondents from the CSO sector to the questionnaire confirmed that providing funds for CSO capacity building was an important benefit of the MeTA project. Unfortunately little information is available on how the coalitions worked to ensure a unified voice and that information from the representatives in the MeTA governing councils and working groups is made available to coalition members.

In terms of 'getting a place at the table' and being accepted by government as a valued partner progress has been made particularly in Jordan and Kyrgyzstan, two countries with a political context and/or culture that did not foster direct civic participation. In Kyrgyzstan this process was facilitated by obtaining strong support of senior government officials to the priorities identified in the MeTA work plan, and a common understanding that the existing responsibilities and powers of the MRA (resisting involvement of CSO in policy dialogue) were beyond the agency's mandate. Similarly, in Jordan, there was strong government support to the MeTA principles of multi-stakeholder engagement and transparency. Feedback from CSO respondents on the questionnaire confirmed that providing the opportunity of CSOs to participate in policy dialogue with government was an important achievement of MeTA.

The recommendation from the DFID 2014 Annual Review to accelerate roll out of the CSO capacity assessment tool was not implemented, one reason being that the initial study in Ghana was delayed.

5.5 Engagement by policy makers in multi stakeholder policy dialogue for access to medicines policies (Output 5)

Clear definitions of what is to be understood as 'policy dialogue' or 'policy maker' in the context of MeTA could not be identified. From the activities implemented under this output it can be assumed that policy dialogue was mostly seen as discussion of issues and related policy options or recommendations during specific meetings. Not in all cases a clear expected output of the policy dialogue was defined. Judging from the work plans and country progress reports not all countries had a common understanding of what policy dialogue entails. While there is no single definition of policy dialogue in the literature, common features include evidence based multi-stakeholder dialogue with a clearly defined expected output (e.g. consensus – if possible - on policy solution). Examples for how policy dialogue has been described by participants of a WHO/EU 'Technical Meeting on Sharing Experiences on Health Policy Dialogue in low- and middle-income Countries' are provided in the text box.[23]

Policy dialogue was described by participants at a non-MeTA related technical meeting on policy dialogue in Brazzaville as:

- "An iterative process connecting the technical to the political, addressing the aspirations of the people, involving multiple stakeholders aiming to change formal or informal policy, strategy and plans informed by evidence to have maximum (public) health impact"
- "A participatory inclusive approach amongst all relevant stakeholders around a specific issue with the aim of agreeing on overall policy directions with the essential elements of being face-to-face and interactive"
- "A continuous process at several levels which is dynamic and creates interactions; it is also a step-wise process on a topic that interests all (common good) around the resolution of an issue of societal (common) interest. It should lead to a decision on change which is accepted"

The end-of-project target for Output 5 was that at least one evidence based policy recommendation has been put forward in a multi-stakeholder dialogue in all countries. As per DFID Annual Review 2015 this target was achieved in all seven countries by mid-2015. Findings of studies from MeTA Pilot Phase, MeTA Phase II and other sources were used for example to provide policy recommendations in the context of MeTA involvement in the review of National Medicines Policies (Ghana, Jordan, Kyrgyzstan, Uganda) or for the review of medicines legislation (Zambia – based on pilot phase

[23] Policy dialogue: What it is and how it can contribute to evidence-informed decision-making. Briefing Note. Geneva, 2015: World Health Organization & Alliance for Health Policy and Systems Research

position paper). Practice recommendations based on assessment of medicines promotion were made for example in the Philippines (update of pharmacy and medicines training curricula). Table 6 provides information on achievements in each of the seven countries mainly based on their work plans and progress reports for Output 5. Question marks in the 'Outcomes' column mean that the outcome was not always clearly communicated or described in the documentation available to the review team.

Table 6 – Policy dialogue in multi-stakeholder setting

	Themes / activities	Outcomes
Ghana	• Multi-stakeholder forum on quality of medicines; • Multi-stakeholder forum on medicines prices • Policy recommendation on medicines pricing produced • Policy recommendation on transparency produced	• Discussion forum • Stakeholders signed Communiqué on prices; prescribing; cost-effectiveness; and transparency • VAT exemption for selected Active Pharmaceutical Ingredients and probably for selected locally manufactured essential medicines • Both documents submitted to National Medicines Policy Review Technical Committee; policy to have a new section on transparency
Jordan	• Multi-stakeholder working group: review of Jordan disclosure survey; • Multi-stakeholder working group: developing policies to improve rational medicines use • Multi-stakeholder working group: revising National Medicines Policy	• Disclosure Policy for various government institutions approved by MOH • Policy document on Pharmacy & Therapeutics Committees in Jordan endorsed by MOH • Approved revised National Medicines Policy (with section on transparency under drug regulation) & implementation plan
Kyrgyzstan	• Support to revision of National Medicines Policy & organisation of round tables for affected stakeholder groups • Support to review medicines legislation regarding susceptibility to corruption (MeTA expert groups & technical assistance) • Round Table discussion on improving public procurement • Round table to discuss draft of revised medicines legislation (June 2015)	• Revised National Medicines Policy (including comprehensive situation analysis & principles of transparency) approved by government & supported by stakeholders • Draft legislation; MeTA support to stakeholder consultations (round tables) • Resolution to be sent to public sector decision makers • Progress report not yet available

	Themes / activities	Outcomes
Peru	• Identification and discussion of problem of high prices of Atazanavir • Drug policy dialogue meetings in 4 cities • Discussions on access to biosimilars • International workshop on biotechnology products (also addressing issues related to access to anti-cancer medicines) • Seminar on Intellectual Property Rights and access to medicines	• Recommendation on compulsory licensing of Atazanavir (2 letters to Minister of Health); case discussed with MRA • Outcomes of the other activities not documented
Philippines	• MeTA Policy Dialogue Series with clearly articulated objectives and expected outcomes • Public consultation of draft Philippine Code of Business Ethics for Promotion and Marketing	• Understanding MRA Fee restructuring scheme; Consolidated industry position paper submitted to the MRA in April 2014 • Outcome not documented
Uganda	• Medicines prices & availability report shared during meeting • Dissemination of client satisfaction survey • Quality of Medicines Forum to discuss disclosure options • Support to multi-stakeholder consultation on revision of National Medicines Policy & Strategic Plan	• CSO statement for policy makers • Informed 2013 Annual Health Sector Performance Report (UNHCO client satisfaction survey – funded by World Bank Institute) • Key recommendations on disclosure, citizen engagement, supply chain actors etc. made • Revised National Medicines Policy & Plan approved
Zambia	• Presented position paper on health shops (from pilot phase) to government • Met with Minister of Health mentioning reports from pilot phase • Round table to discuss study on public procurement & impact on local manufacturing	• Updated medicines legislation provides for health shops • Support to MeTA; agreement to organise round table meeting • Local manufacturers entered into framework contracts for selected products on government tender

Policy dialogue in countries was not always based on MeTA originated information, reports or analyses. However, it could also be seen as a MeTA achievement that available evidence was used during MeTA facilitated dialogue sessions.

Not all policy and practice recommendations resulting from policy dialogue are included under Output 5 in countries' work plans and progress reports. Important examples include recommendations to Ministry of Health for monitoring of medicines through a harmonised tool based on discussions within the Uganda MeTA Council of evidence from the medicines availability and pricing study – this recommendation was accepted; a position paper submitted to the Ministry of Health resulting from a forum discussing the results of the mapping of national government medicines access programmes in the Philippines; and a forum and round table discussions on the mapping of patient organisations and development of a framework for engagement leading to a

Patients Conference Manifesto presented to the Ministry of Health and planned to be the subject for a MeTA Policy dialogue (outcome not yet known).

In Peru policy dialogue seems to have happened mainly within the MeTA council. The work plan for 2014/15 provides for three national and two regional round tables where topics were yet to be identified by the MeTA Assembly. The available progress reports do not yet provide more detailed information on implementation. In general, MeTA Peru notes that policy dialogue is still weak.

Progress reports of MeTA Kyrgyzstan are very detailed and provide good insights in processes and challenges. For example, discussion with business sector stakeholders on private sector ethics and medicines promotion revealed strong division within the sector and MeTA decided to not pursue this issue and rather concentrate on other priorities with a better chance for success.

5.6 Engagement with MeTA increases (Output 6)

The revised log frame contains two indicators for Output 6, one related to global awareness and support and one related to increased collaboration of global or national stakeholders with MeTA.

It appears that expectations under this output were not quite clear to countries: Jordan, Kyrgyzstan, Philippines, Uganda and Zambia did not include any Output 6 activities in their project log frames, but provided feedback on milestones in their progress reports. Kyrgyzstan and Peru included relevant activities under Output 1.

Table 7 – Collaboration in countries with global or national stakeholders

Ghana	• Complementarities between MeTA Ghana and 'Better medicines for children' project on Drug & Therapeutics Committees • MeTA participation in review of National Medicines Policy • MeTA Ghana council member is chair in Ministry of Health Supply Chain Master Plan Technical Committee • IMS MeTA presentation at annual conference of Ghana Pharmacists Association
Jordan	• MeTA contribution to a health facility survey funded by a Canadian Award • Plan to develop communication strategy on MeTA benefits/results for potential donors
Kyrgyzstan	• Active promotion of MeTA to donor partners • Pro-active information of national and global stakeholders on medicines policy (including at annual health sector reform programme review); • Coordination and information sharing meetings with World Bank pharmaceutical policy specialist, also for getting support that medicines become one of the priority areas for monitoring of the health sector reform programme • Participation in 2014 Joint Annual Review
Peru	• 2014/15 work plan: include international partners as members in council
Philippines	• Implemented project on Codes of Business Ethics with funding from British Embassy • Implemented training course on Leadership, Governance and Transparency in Pharmaceutical Management in formal partnership with two CSOs
Uganda	• MeTA CSOs received funding from Management Sciences for Health for community empowerment in line with MeTA principles • MeTA CSOs received funding from DFID (accountability project), USAID (advocacy; supply chain; social accountability), World Bank Institute (social accountability) – all projects in line with MeTA principles and work plan • Requested DFID for additional funding to scale up medicines price & availability monitoring (no response)
Zambia	• Reports that MeTA stakeholder groups maintained collaboration

The IMS and DFID Annual Review reports include additional information on national level collaborations, for example the collaboration with the EU/ACP/WHO Renewed Partnership on Pharmaceutical Systems Strengthening in Ghana and Zambia. It is also stated that MeTA Zambia and MeTA Uganda will be involved in 2016 in the Health Systems Advocacy for Africa (HSA4A) Partnership, a project funded by the Dutch Ministry of Foreign Affairs and implemented by an alliance of AMREF Health Africa, the African Centre for Global Health and Social Transformation (Achest), HAI and WEMOS. The project is focussing on civil society capacity building and advocacy for amongst others access to sexual and reproductive health medicines.[24] However, it is not clear how MeTA involvement will look like in practise and whether this will be in the form of formal partnerships.

In the same vein, in case some MeTA member CSOs received funding from other sources it is not clear what MeTA's involvement is and whether there is explicit collaboration or – in the worst case – rather competition. Another point for clarification is whether the participation of individual MeTA council members in other relevant activities can be interpreted as representing MeTA. For example, being appointed as chair of the supply chain master plan technical committee in Ghana might be because of the individual's position in the Ministry of Health rather than because of being member of the MeTA council.

Related to promotion of MeTA at international level DFID Annual Review reports list a number of presentations, guest lectures and workshops directly or indirectly related to MeTA delivered by either WHO EMP or HAI, and engagement of HAI with the Kings College/London regarding support to MeTA Kyrgyzstan and Philippines.

Without a stakeholder survey it might be difficult to further assess the impact of these activities.

5.7 MeTA contribution to better policies and access to medicines

As a conclusion for Chapter 5 we present examples in the text boxes below for how MeTA contributed to better pharmaceutical policies, practices and access to medicines. In addition to the general project documentation, some of these examples are informed by the MeTA brochures produced by countries with support of WHO.[25]

Ghana

Improved availability and affordability of locally manufactured essential medicines
In order to increase competitiveness and affordability of locally produced medicines the Government decided in 2014 to exempt Active Pharmaceutical Ingredients for selected priority products from Value Added Tax (VAT). This was supposed to be followed in 2015 by a removal of VAT for selected locally produced pharmaceuticals and some of the related raw materials.

What was MeTA's role?
The MeTA council organised a multi-stakeholder forum in 2014 to discuss affordability of medicines in general and in the context of the National Health Insurance Fund in particular. The forum concluded with a 'Communiqué' directed to the Minister of Health. On pricing the Communiqué recommends to reduce import duties, taxes and other levies on medicines, and that medicines included in the national essential

[24] See http://haiweb.org/work-area/sexual-reproductive-health/ and http://achest.org/index.php?option=com_zoo&task=item&item_id=136&Itemid=459 – accessed 8 January 2016
[25] See specific country pages at http://www.who.int/medicines/areas/coordination/meta/en/

medicines list should be tax exempt. MeTA also prepared a policy recommendation paper for the medicines policy review committee. This paper used evidence from previous medicines price component surveys of the impact of VAT on final medicines prices to argue for an exemption from VAT for essential medicines.
MeTA Ghana considers that without its involvement specific activities in the pharmaceutical sector might not have been addressed at all. The multi-stakeholder fora were effective for sharing ideas and arriving at policy commitments.

Jordan

Improved availability and affordability of essential medicines
According to a 2014 survey average prices for 50 branded medicines fell from 19 to 14.5 times the international reference price in 2009. The ratio for generic medicines was from 9.75 to 9.07 for the same period. National Health Accounts for 2008 show that medicines expenditure comprised 36.3% of the total health budget. By 2012 it was 26.75%
With regard to availability of essential medicines in the public sector, a 2014 assessment found an increase from 79% in 2009 to 86.7%. The availability of 50 key medicines in the public and private sectors rose from 62.9% to 75% during the same period.

What was MeTA's role?
The MeTA Council is respected and has weight due to its membership and government approval as a national mechanism that addresses and includes all issues and actors i.e. it is an inclusive national forum and process rather than a global project.
Specifically the Council established 6 technical working groups under the overall rubric of revision of the National Medicines Policy, last revised in 2002 and reportedly largely forgotten. One group specifically reviewed the causes for high medicines prices and pinpointed the longstanding use of reference prices in a selection of high-income countries, linked to governments wish to export a range of locally produced medicines for optimal profit.
MeTA Jordan assigns impact to the discipline and structure achieved by the MeTA process over the previously fragmented activities, including the creation of a broad overview of the entire medicines chain, a subsequent consensus by the Council membership on national medicines problems and priorities and a new national policy to address them. The policy implementation is now overseen by a Task Force which monitors specific target indicators.

Kyrgyzstan

Improving procurement of quality assured medicines
MeTA Kyrgyzstan succeeded in changing national procurement policy including the insertion of a new clause in the associated procurement law. Previous national procurement policy applied to procurement by all public authorities, including health, and required purchases at the lowest price. The new law governing medicines procurement prescribes medicines' efficiency, quality and safety as the priority criteria over price.
Although the new law has taken effect, its impact on quality of care and patient trust remain to be seen.

What was MeTA's role?
The above is one example of MeTA's role in the revision of national medicines policy which was undertaken at the request of the MOH. It is reported that MeTA led a two year process of stakeholder consultation as well as steering the political process. The involvement of civil society is reported to have been particularly important, correcting a previously one-sided technocratic approach. MeTA has achieved a reputation as the body that convenes all stakeholders on a basis of equality and respect.

Peru

Improved transparency on medicines prices, availability and quality
In order to enable consumers to find best prices for their medicines MeTA established a medicines price observatory website which provides current information on both prices and availability of pharmaceutical products The website is now hosted by the Ministry of Health. Some 6000 entities are said to report to it regularly on their current prices and availability.
The observatory has also served as a vital tool for policy making on medicines more broadly. In 2014 it provided data for a public commission working on medicines tax exemptions.

What was MeTA's role?
During the Pilot Phase MeTA established the initial version of the observatory and under Phase II provided support for its redesign, and for establishment of the availability and quality observatories. A MeTA working group drafted the necessary legislation which was adopted by government.
Analysis of information from MeTA suggests that a special emphasis is given to strengthening the role and participation of civil society and to be a proponent of patients' rights, not least the right to information.

Philippines

Improved access to safe and quality assured medicines
In 2013 MeTA commissioned the first independent mapping of medicines access programmes in response to its previous findings that a government process to cap medicine prices had only impacted the expensive branded medicines and not those frequently used by the poor. Discussion of the mapping results prompted CHAT (stakeholder CSO) to implement monitoring of availability, prices and quality of medicines at community level as a lever for improvements.
The review was unable to confirm the impact and outcome of this process.

What was MeTA's role?
MeTA Philippines considers that its principal strengths are its wide and representative membership Forum, served by a small group of Trustees which is seen to ensure wide consultation and participation in both development of its plan of action. The above is just one example.
The particular added value of MeTA is felt to be communication of information, promoting dialogue amongst all stakeholders and consensus building.

Uganda

Improved transparency on quality of medicines
MeTA Uganda supported the National Drug Authority (NDA) to conduct quality assessments of a sample of pharmaceutical products available on the market in rural areas in 4 districts. The NDA was initially reluctant to publish findings of the assessment. MeTA Uganda then facilitated a 'Quality of Medicines' forum for information sharing with participants from Ministry of Health, NDA, Uganda Health Supply Chain Project, Public Procurement and Disposal Authority, Joint Medical Store, HAI, WHO Geneva, WHO Uganda, MeTA international secretariat, private pharmaceutical manufacturers, civil society and media. The forum concluded with a number of recommendations including on increased transparency on quality of medicines by the NDA.
The National Pharmaceutical Sector Strategic Plan launched in November 2015 includes information sharing fora on quality of medicines as one of the strategic interventions.

What was MeTA's role?
It has been noted that MeTA Uganda has rightly prioritised medicines quality which had not been discussed openly before. Engagement with the NDA was a difficult process but finally successful for

advancing transparency. Through MeTA a collaboration platform for public, private and civil society sectors was created that did not exist before.

Zambia

Better access to quality assured medicines in rural areas
During the Pilot Phase MeTA Zambia prepared a position paper on illegal drug stores operating in rural areas including a proposal to adopt the 'Accredited Drug Dispensing Outlet' model implemented in Tanzania. The paper was discussed with Ministry of Health and Ministry of Commerce officials and during MeTA fora and radio shows. This contributed to the provision for health shop in the Medicines and Allied Substances Act of 2013.

What was MeTA's role?
For MeTA Zambia the role of the MeTA chair, an active member of parliament, was found important for maintaining dialogue with government. MeTA also successfully engaged private sector pharmacists for endorsement of the health shops concept. The MeTA Zambia Executive Committee considers that while other actors contributed to achievements, MeTA often provided the necessary push to make things happen.

6 PROJECT MANAGEMENT

6.1 Project management and operational arrangements

The experiences and lessons learnt in the Pilot Phase led to changes in arrangements for Phase II. These included a shift from the top-down "consultancy" approach to a more country driven model.

The tripartite structure of IMS in the Pilot Phase was replaced by HAI and WHO. We were surprised by this decision given the recommendations of the Pilot Evaluation to the effect that an ineffective tripartite management should be replaced by a unified structure, including common geographical location, with clear leadership and well defined roles and functions.

The DFID business case for MeTA Phase II explains the rationale for this decision. DFID subsequently signed separate MoUs with each organization with the aim of formalising management arrangements and responsibilities. Signature with HAI took place in August 2011 and with WHO in September 2011. Subsequently WHO and HAI drafted a project collaborative agreement with the aim of further defining the respective roles and responsibilities of each organization (see below).

The MeTA Management Board (MMB) and the International Advisory Group (IAG) were dissolved, presumably due to their poor value and high cost as noted by the pilot evaluation. Instead IMS reported directly to DFID project managers. International communications functions such as high level profiling were also dropped.

It was reported that there were 5 changes of DFID officials responsible for the MeTA project during Phase II. Since each had particular priorities there was a resultant loss of continuity.

In order to try to streamline roles and functions and their budgetary management implications, it was agreed that HAI would take responsibility for administrative functions whilst WHO would provide technical support. In principle this was in line with the budgetary allocation by DFID.

Administrative functions were further defined to include, **at country level**, support to countries for Output 1 (functioning MeTA Councils) and Output 4 (building CSO capacity, mainly through workshops and support for CSO work plans) and, **at global level,** included organization of IMS meetings, teleconferences with countries and minute taking.

We note that activities related to Output 4 included CSO training that focused on specific governance issues including conflict of interest, advocacy, communication and promotion. These are important technical issues that should be included in future MeTA programmes.

The formal technical role was assigned to Output 2 (data collection), Output 3 (Dissemination of information) and Output 5 (policy dialogue). Technical functions included review of terms of reference for technical work, project proposals and reports; organization of training and review of impact indicators.

We were informed that some occasional overlaps occurred, for example, when uncertainty arose with regard to assigning activities to particular outputs. We assume these bore some transaction costs to resolve, even if minor. For example, MeTA Zambia reported that activities that had been planned to be funded as technical activities had to be shifted to the administrative funding stream.

WHO technical support was provided by staff at Headquarter (HQ) EMP department, Regional Offices and Country Offices, as well as external experts. WHO staff in Ghana, Jordan, Peru, and Uganda were in position at the start of Phase II and had a long experience in WHO and expertise in pharmaceutical sector issues. Staff were recruited in Kyrgyzstan, Philippines, and Zambia specifically for their knowledge and experience in the sector.

These arrangements were subsequently explained to national councils during country visits.

We are concerned that no preparations were made by IMS for their role in cooperating with representatives of the private pharmaceutical sector since neither HAI nor WHO have recognised experience in this regard. We appreciate that interaction with all three sectors took place within the context of their membership of multi-stakeholder groups in each country. However, this was unlikely to be an effective way to address the specific weaknesses in private sector engagement in MeTA that were identified in the Pilot Evaluation (see Section 4.2 above).

6.2 Phase II start-up

As noted in Chapter 4, arrangements for Phase II took time to finalise with the result that Phase II official start –up took place in August 2012, some 10 months following the end of the Pilot Phase. In practice start-up of implementation in countries ranged from 2012 to 2013.

The momentum achieved by national councils during the Pilot Phase was seriously affected due to a delay in funding. In addition the budget for administrative activities during Phase II was reduced. Consequently, with the exception of Kyrgyzstan, Philippines and Uganda, most councils ceased to function.

During the first year of Phase II it is reported that IMS made considerable efforts to help countries to revive councils, especially to recruit new coordinators, new WHO medicines advisers, and to find new office arrangements. For example, HAI provided support for the recruitment of coordinators in all countries.

WHO Country Office representatives supported the coordination function in Ghana, Jordan, and Peru until coordinators were recruited. WHO Country Offices provided meeting rooms for MeTA council meetings in Ghana, Jordan, Peru, Philippines, Uganda either on a regular or intermittent basis.

In view of the subsequent successful achievements by all national councils it is evident that the IMS intervention was exceptionally effective with regard to damage limitation. Nevertheless, most responses to our questionnaire to council members cited this delay as the most serious obstacle they had faced during Phase II. One country claimed that they never regained the successful momentum they had built up during the Pilot Phase. We suggest that the design and planning of future MeTA projects should include measures to avoid such delays.

6.3 Governance, management and operational arrangements for support to MeTA national councils

The establishment of national councils in the Pilot Phase benefitted from extensive guidance and provision of management guidelines and administrative templates e.g. for financial accountability. Most Phase II councils retained at least some members from the Pilot Phase who were able to provide advice on governance and managerial arrangements derived from lessons learnt. To this extent they were decided nationally and varied from country to country. (See Table)

Only one country, Peru, signed a formal agreement with the government to participate in Phase II. The pilot evaluation recommended that Councils should have written constitutions/internal rules. Whilst Jordan and Philippines implemented this recommendation, most countries retained a similar governance structure as in the pilot phase. Zambia established an executive committee. In contrast, Peru abandoned its executive committee and transferred responsibility to the council.

It is unclear to what extent council members were prepared for their roles. It is assumed that lessons from the Pilot Phase were passed on by those members who continued into Phase II. We question whether this was an adequate preparation in view of the subsequent suspicions and disputes that were reported by some councils. In some cases these were reportedly due to unfamiliarity with the roles of CSOs and stereotyped images about their methods. In some cases there was a lack of trust with regard to possible interests on the part of some members e.g. private sector. These are surely to be expected given the nature and complexity of factors influencing access to medicines.

We suggest that any future MeTA programmes in countries should include **preparatory orientation** of council members with the aim of creating understanding of both their interests and potential contributions and creating trust between them. We note that guidance for preparation of the pilot phase, made available on the MeTA website, included this proposal.

(Ref: www.medicinestransparency.org/key-issues/multi-stakeholder-alliance/)

Many council members expressed regret that Phase II made only limited provision for **inter-country learning**. There was unanimous appreciation for the global meeting that took place in December 2014 but most respondents felt it took place too late to benefit the remainder of the project in their countries.

CSO representatives also benefitted from an international workshop hosted by HAI in Amsterdam.

It was reported that WHO also experimented with bilateral WebEx meetings as a means of sharing information and giving technical advice. These were discontinued due to difficulties encountered with language and time differences as well as lack of necessary technology in some countries.

Positive experience has been gained through the participation by invited MeTA council representatives in a range of meetings including WHO seminars, the University of Utrecht Summer Course on Pharmaceutical Policy, the WHO/GGM bi-regional meetings jointly organised by WPRO and SEARO and the WHO Collaborating Centre for Pharmaceutical Pricing and Reimbursement Policies Conferences.

We were disappointed to note that the MeTA website is largely out of date. Whilst it contains useful information, it sends a negative signal.

6.4 Development of council work plans

According to the DFID 2013 Annual Review Report all countries successfully completed baseline surveys and analyses during the Pilot Phase and these were the basis for development of a first one year work plan for Phase II.

The process of planning for the entire period of Phase II was reported to be lengthy as councils were being re-established and staff was being recruited in parallel to the planning process. Efforts were made to draw on local expertise for carrying out technical work to both improve country ownership and to improve capacity.

We have briefly reviewed work plans which are available on the MeTA website and we confirm that they are detailed, in line with country problems and priorities. However, there is no evidence that efforts were made to align the MeTA work plans with existing Ministry of Health pharmaceutical sector work plans.

Questionnaire responses mostly confirmed strong appreciation for IMS support in both development and implementation of work plans. One important reservation related to **delays in release of funds** for technical activities on the part of some WHO Country Offices, especially in the African Region.

6.5 WHO technical guidance to national councils

For each technical activity WHO staff at Country, Regional and/or HQ reviewed the terms of reference, the protocol and the subsequent report for the activity. The decision on where to carry out the review was based on the expertise and resources available. For example, the Kyrgyz National Medicines Policy review took place in the WHO Regional Office for Europe, the Ugandan quality of medicines protocol at HQ and the mapping of drug entitlement programmes in the Philippines took place at the WHO Country Office in Manila.

At WHO/HQ the programme was able to call upon necessary advice, such as medicines regulation, from appropriate experts across the EMP Department. WHO Collaborating Centres were also engaged, such as for the workshops on pharmaco-economics in Jordan and Uganda.

If WHO expertise was unavailable, technical guidance was also provided through consultants, either local or international. An example is the National Medicines Policy review in Uganda.

WHO did not develop any new tools or guidelines for MeTA. Instead existing materials were made available:

- Pharmaceutical sector country profile data collection tool
- How to investigate drug use in facilities
- Measuring medicines prices, availability, affordability and price components (WHO, HAI)
- Measuring transparency in the public pharmaceutical sector
- WHO guideline on country pharmaceutical pricing policies
- How to develop and implement a national medicines policy
- Drugs and therapeutic committees- a practical guide
- WHO Operational package for assessing, monitoring and evaluating country pharmaceutical situations

DFID had initially put a strong focus on application of new data collection tools in MeTA countries. Whilst no new tools were developed during the project period, significant improvements were reportedly achieved with regard to the price and availability methodology based on country needs assessments and analysis of country data.

6.6 Budget

The DFID budget totalled £6 million for the Phase II programme period. The allocations for administrative and technical functions were £2.4 million and £3.6 million respectively. An amount of £140 000 was retained from this total to meet the costs of programme evaluations.

The funds for administrative support included the cost for two staff at HAI HQ, travel costs and costs related to Outputs 1 and 4 in countries.

The funds for technical support included staff and activity costs at WHO HQ and WHO Country Offices. Country Offices were expected to contribute 50% to staff salaries where they were engaged in programmes in addition to MeTA.

The budget was managed from WHO HQ and fixed amounts were sent to country offices following the approval of MeTA work plans. Country Offices then managed the disbursement of funds in line with the MeTA work plans. Once the activities were implemented, countries could request additional funds.

As noted in Section 6.4 above, national councils in Ghana, Uganda and Zambia reported delays in release of funds that they found very disruptive.

A few countries benefitted from other WHO programmes that had synergies with MeTA such as the WHO/EC/ACP Renewed Partnership.

In kind resources were provided to MeTA by WHO mainly through office space and sometimes office services such as use of computers, printers or secretarial services.

7 SUSTAINABILITY

The 2014 DFID Annual Review noted that a key challenge for the remainder of the programme was to demonstrate improved sustainability in participating countries. To this end countries were required to prepare sustainability plans. Sustainability has been interpreted to include both financial sustainability as well as the sustainability of results in countries.

Experience accumulated during Phase II has shown that specific country context is one important driver of sustainability, particularly the extent of government interest and support and the degree of integration of MeTA processes into government. (DFID Annual Review 2014) Jordan, Kyrgyzstan and Peru have been seen to perform well in this regard. Sub-contracting by government may be a possible source of funding support in Kyrgyzstan and Philippines.

A second factor is high level political support and stability of political systems. Sustainability in Peru and Ghana has been challenged on this basis.

A third key factor is MeTA's visibility in countries where there are many high-profile medicines and health programmes, many supported by external agencies demanding privileged, high-level government attention and approval. Respect and demand for MeTA to link with such programmes can contribute both to sustaining MeTA processes and to its financial sustainability. MeTA in Uganda and Zambia are reported to benefit from engagement with a Dutch-funded project as well as the WHO/EC/ACP Renewed Partnership programme.

Increasing concern about sustainability prompted a new requirement by DFID in its 2014 Annual Review that countries prepare sustainability plans during 2015. The DFID Annual Report 2015 confirmed that, with the exception of Ghana, all have been judged feasible.

The 2015 Annual Review noted that securing civil society funding is a particular challenge and is largely dependent on external sources. HAI has responded to this challenge by supporting CSOs in Kyrgyzstan, Philippines, Uganda and Zambia to develop funding proposals to be included in its requests for funding that target respectively sexual and reproductive health and non-communicable diseases. The country proposals concentrate on specific aspects of MeTA action i.e. maintaining multi-stakeholder councils and promoting multi-stakeholder engagement. The results of this initiative remain to be confirmed.

As the programme approaches its end, we find that financial sustainability seems far from assured in most if not all countries. It notes that financial and in-kind support to MeTA peaked in 2014 and actually dropped in 2015 in most countries (Ref: DFID Annual Review 2015).

Furthermore, there is a risk that fund-raising, including integration into wider donor-funded projects, could serve to blur MeTA visibility and its unique focus on promoting access to quality medicines through the influence of transparency and policy dialogue on medicines markets led by independent multi-stakeholder forums.

There are important roles for WHO and HAI in the short term to serve as advocates for MeTA sustainability in the seven participating countries.

In the longer term WHO should consider integrating the MeTA approach into its mainstream programmes aimed at increasing access to medicines. In view of the apparent increased interest by Member States in good governance in health systems, one possibility would be to amalgamate the

MeTA approach and processes with GGM, thereby reinforcing and integrating country-focused efforts across the totality of the medicines chain.

8 CONCLUSIONS (OUTCOME, IMPACT AND VALUE FOR MONEY)

8.1 Has MeTA achieved its aims?

The MeTA pilot evaluation found that multi-stakeholder collaboration was possible and led to more relevant sector information being available. However the duration of the pilot phase had been too short to see relevant progress in data disclosure or MeTA's contribution to changes in national medicines policies or business practice. Consequently, MeTA Phase II expected to progress from collecting and sharing data to using this data and the multi-stakeholder dialogue to influence policy making and implementation.

Chapter 5 confirms that MeTA Phase II was successful when achievements are compared with log frame expectations. It achieved its principal Expected Outcome on the basis that all countries have achieved all four Outcome Indicators (Ref: DFID Annual Review 2015) and it largely achieved each of the six Expected Outputs (See Chapter 5).

We conclude that Phase II objectives were relevant. However, the strong performance by some countries suggests that more ambitious objectives would be warranted in any future programmes.

8.2 Did MeTA address the needs of beneficiaries and stakeholders?

DFID Annual Review Reports describe two groups of potential beneficiaries. The primary beneficiaries should be the general public, especially the poor, who should be able to access the medicines they need at a reasonable price.

The review found evidence that this had occurred in three countries, first in Jordan due to a change in pricing policy which took place in 2009; secondly in Peru where the creation of a price observatory had a positive impact on access to medicines by informing people on price variations and where to obtain quality medicines at the best available prices; and thirdly in Philippines through its contribution to legislation (Universally Accessible Cheaper and Quality Medicines Act, 2008).

We also found positive examples of changes in medicines policies in other countries that have potential to improve access to medicines. More effort and time will be required to translate policy change into practice.

The second group of beneficiaries comprises the MeTA stakeholders and the sectors that they represent. Chapter 5 summarises the outputs and achievements in each country.

We found that all 3 sectors represented on national councils benefitted from both access to good information as well as participation in the dialogue that led to policy recommendations to government. However it has proved difficult to determine the precise interests, roles and functions relating to representatives of each sector. Consequently we have been unable to determine whether the information made available to councils was always used exclusively to advance the objective of improving access to medicines or whether there may have been any significant conflicts of interests.

8.3 Achievements in the pharmaceutical sector in countries?

Transparency

We conclude that the programme has made a positive contribution to improving transparency in the pharmaceutical sector in participating countries.

All countries disseminated information and findings from data collection and analysis using methods that include MeTA country websites, government websites including MRAs, videos, electronic newsletters and distribution of document hard copies. (See Table 3, Chapter 5).

However countries displayed wide differences both in the extent and the methods used to share policy-related information, including reports of MeTA council discussions. A few countries restricted information sharing to within the council itself. Others committed much greater effort through mechanisms such as round table discussions, focus group meetings, presentations at non-MeTA events, newspapers and radio broadcasts. (Table 3, Chapter 5). One country developed a dedicated communications strategy.

We conclude that important information does not always reach stakeholders, both decision makers as well as the general public.

With regard to the role of CSOs in information sharing and advocacy, we found that providing funds for CSO capacity building was an important benefit of the MeTA project. Unfortunately little information is available on how the coalitions worked to ensure a unified voice and that information from the representatives in the MeTA governing councils and working groups is made available to coalition members.

In summary the differences in effort and achievements with regard to improving transparency indicate that greater attention will be required in the preparation of future MeTA programmes to ensure more effective sharing of information. This will include clarifying the difference between transparency and disclosure.

According to WHO/GGM documentation, transparency simply means "openness in sharing information and that information is publicly and easily accessible for those who need it"[26]. Disclosure, however, implies a more purposeful effort to provide selected information to those who need it.

We agree with the conclusion of the report of the MeTA Pilot Evaluation that *"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 it."*

Accountability and governance

The MeTA model assumes that availability of information is adequate in itself to improve accountability and strengthen governance. In practice the reviewers have found it difficult to trace a link between the two. In part there is a conceptual difficulty.

Accountability is one basic ingredient of good governance. However sharing of information has other objectives that are important in promoting access to medicines and that are part of MeTA

[26] Baghdadi-Sabeti G, Cohen-Kohler, JC, Wondemagegnehu E, 2009. Measuring transparency in the public pharmaceutical sector - Assessment instrument. Geneva, 2009: World Health Organization

programme assumptions. These are (a) to improve knowledge and awareness and (b) to promote changes in policy and business practice.

All in all it can be concluded that dissemination of information in various forms contributed to access to medicines policy changes, but evidence that increased transparency led to governments being held accountable is still scarce. We note that WHO has commissioned a specific piece of research on this topic

We also found that the programme missed opportunities to improve governance as follows:

- The MeTA website includes copies of guidelines prepared during the pilot phase to help countries set up their national councils. They include the following expectation with regard to the contributions by sectoral representatives:

  > *"MeTA engages public, private and CSO sectors together in permanent multistakeholder forums in which **each sector commits to specific common objectives, and specific roles and functions**."*

  The review found no reference to any activities aimed at specifying the roles and functions to be undertaken by each sector, or to indicators that would enable an objective assessment to be made. This is likely to be a particular challenge for private stakeholders whose primary interests may lie within very specific aspects of the pharmaceutical sector.
  We conclude that the MeTA methodology should include more emphasis on targeting and promoting changes in business practice that relate to improving access to medicines.
- Most national councils have failed to demonstrate adherence to international standards of good governance as already noted in the pilot evaluation. For example, only Jordan and Philippines require council members to sign Conflict of Interest declarations.
- Most national councils ignored possible opportunities to benefit from complementarities with other relevant programmes e.g. WHO's GGM programme (with the exception of limited efforts in Jordan and Philippines).

At the global level the pilot evaluation criticized MeTA for non-compliance with international standards of good governance in development cooperation (Paris Principles). The main criticism was a failure to integrate country programme planning and implementation within national health sector processes. Phase II actions in Kyrgyzstan and Uganda in support of national medicines policy reform were situated within a broader health sector strategy review. However we found no evidence to suggest that this criticism was addressed in arrangements for Phase II in other countries.

Policy and practice

We found that all MeTA Councils have used their analytical information products as the basis for policy dialogue. However we noted that what is labelled as "policy dialogue" does not always engage those who make policy. Rather dialogue has led to recommendations on policy change. Examples of recommendations for change in practice are more limited.

In some cases where MeTA can be regarded as institutionalized, it seems clear that MeTA action directly influenced important changes in national medicines policy. Councils in other countries made very specific recommendations that led to adoption of new laws and procedures with a more limited focus or to the adoption of new procedures for monitoring and reporting. These examples are of a

different order but all can be regarded as significant achievements within the complex arena of efforts to improve access to medicines.

In conclusion we find that MeTA has given rise to a wide range of policy-relevant outputs as well as a small number of changes in practice. Contributions to significant policy change have been more modest. The latter have been achieved in circumstances where MeTA is well embedded within national processes for policy making.

8.4 Did MeTA contribute to strengthening health systems?

The programme did not include any explicit objectives with regard to strengthening health systems. However, we found explicit health systems recommendations to government in two council work plans (Philippines and Zambia).

According to WHO guidelines on health systems, capacity to ensure access to essential medicines is one of six fundamental "building blocks" of sustainable health systems. It is closely dependent on two other "building blocks" i.e. capacity to deliver health services and good governance in the health and pharmaceutical sectors. In other words we must assume that MeTA has included **implicit intent** to strengthen health systems.

The WHO guidelines define these capacities with reference to ensuring effective procurement, strengthening management and supply of essential medicines and technologies, as well as ensuring strong oversight capacities.

These capacities are dependent on good quality information on prices; reliable manufacturing practices including quality assessment; systems for procurement, supply, storage and distribution that ensure availability of safe, quality medicines and prevent wastage; and promotion and oversight that ensure rationale use and prevent unethical promotion. MeTA programme outputs and activities target many of these capacities and evidence of their inclusion in country activities is included in Chapter 5 above.

On this basis we conclude that the programme has made a positive contribution to strengthening health systems.

8.5 Value for money?

The DFID Annual Report concludes that the MeTA programme provided value for money. The programme concept includes the idea that MeTA seeks to catalyse rather than to finance infrastructure, delivery systems or commodities (Annual report 2013). We have also noted that planning for Phase II accorded high priority to containing costs and seeking efficiencies.

However value for money is a function of the total resources that contributed to results. In addition to the £6 million core budget provided by DFID, WHO has contributed resources through technical cooperation activities which would have been extremely costly had they been delivered through private consultants. Individual national councils mobilized domestic resources on their own account. (See Chapter 6).

Although we were not able to calculate the total picture of funds provided for the programme, we have gained a strong impression that the total real funding for MeTA, from all sources, was much in

excess of the DFID provision. It is also apparent that spending on global activities, including administrative and technical support was high relative to expenditure in countries.

Whilst we acknowledge (a) the successful outcomes of MeTA Phase II against the log frame objectives and (b) the efforts made to economise and reduce the *relatively high transaction costs* noted in the pilot evaluation, we are reluctant to conclude that the programme delivered best value for money.

It is our impression that the lessons learnt in Phase II enable any future MeTA programme to design a more cost-effective financing model.

8.6 Has MeTA been a good investment?

The positive achievements by MeTA national councils in each of the participating countries speak for themselves. However the review finds that these need to be weighed against the ability to sustain MeTA activities following the end of DFID funding. A good investment is not something that grinds to a halt once the initial investment has been made. On these grounds it is premature to conclude that MeTA has been a good investment.

9 RECOMMENDATIONS

9.1 Determinants of MeTA progress and impact in countries

The MeTA National Council

The principal determinant of progress is the capacity of the multi-stakeholder forum i.e. the MeTA national council.

Table 8 below contains quotes from the questionnaire enquiry which describe the personal perspectives of individual council members in 4 countries with regard to what MeTA achieved and some reasons for the successes. We have included the table because it helps to paint a more vivid picture of important underlying factors that do not always emerge from data analyses.

Table 9 describes critical enabling and inhibiting factors that appear to determine the performance of national councils. It draws on data from Chapter 5, the questionnaire enquiry and the series of MeTA Country Brochures produced by WHO/EMP.

Table 8 – What was MeTA's greatest success?

Philippines

Prior to MeTA, there was no platform that puts together various sectors that represent opposing interests. There was no venue that would ensure sectors/groups will be listened to without the fear of intimidation or of being judged prematurely.

This is also the main achievement of MeTA in the country – the regular dialogue and open discussions of proposed policies, frameworks and programs that have impact on medicines access, and more broadly on governance, accountability and transparency in the healthcare sector.

Jordan

In the past, there was little information regarding the pharmaceutical sector, and what little there was largely hidden from public scrutiny. Now, through MeTA, a large amount of pharmaceutical information has been collected and made available and will guide policy makers in future reforms.

Uganda

Mutual trust was built amongst stakeholders. Involvement of private sector and CSOs in policy dialogue with Ministry of Health was a key success.

Zambia

Multi-stakeholder processes succeeded in making the private sector aware that medicines need to be affordable.

Table 9 – Why did some national councils perform better than others?

Enabling Factors	Inhibiting Factors
• **High-level endorsement and participation by government** and close physical proximity to key government institutions facilitates dialogue and attention to council advice • Participation by **all three sectors at a senior level is critical for credibility** and influence (Ghana Kyrgyzstan, Jordan and Philippines). • **Ensuring wide representation of relevant stakeholders.** These include academia, medical	• **Ineffective council leadership,** including preoccupation with other business and permitting the council to lose focus and momentum. • **Lack of commitment to regular participation** High turnover of public sector (Kyrgyzstan, Jordan) and lack of quorum (Ghana..), poor private sector participation (Kyrgyzstan) • **Lack of ownership by government** where government was not perceived to be the driver of the process and where access to senior Ministry

Enabling Factors	Inhibiting Factors
stores and particular private sector actors, such as pharmacy chains, wholesalers, private medical practitioners and human rights organisations. • Ensuring **a competent CSO participation**. Common challenges include the resistance to CSO involvement by some parties and the lack of sustained commitment by health officials to CSO involvement. (Global meeting 2014)	of Health representatives was rather low. • **Secretariat lacking technical and administrative capacity** • **Lack of trust between Council leadership and CSOs**. • **Hidden agendas and possible conflicts of interest** of MeTA members
• **Taking the necessary time to build trust and cooperation** between civil society, the private sector and government leads to commitment and coherence. This includes being inclusive of key stakeholders; open to the view of others**;** openly declare interests**;** have clear criteria for representation; and identify opinion leaders for each stakeholder group. (Global Meeting 2014) • **Ensuring that everyone plays an active, relevant and competent role** in the council's work programme sustains trust, strengthens commitment to policy advice and thereby promotes change. • **Ensure active feedback to constituents.** Methods can include annual forum (Ghana, Philippines), website, private sector board meetings (Uganda).	• **Delays in release of funds** (WHO) Delays in release of funds • **Poor conflict management capacities,** most countries had experienced it and advised that willingness to compromise and position-shifting to some extent was crucial. Through further discussions and dialogue, consensus building could be achieved.

Recommendations:

- WHO should use the lessons learnt to prepare **new basic principles and operational guidelines t**o promote the MeTA approach; to help national councils in the seven countries to strengthen their capacities and their sustainability; and as guidance to assist the preparation and planning of future programmes in additional interested countries.
- WHO should develop guidelines to define WHO future technical and managerial support to be provided to countries by WHO staff at country, regional and headquarter levels.
- As a matter of urgency WHO should seek continuing high-level government endorsement and support for their national councils in the seven participating countries as a means of promoting their survival following the end of DFID involvement.

Transparency

More effective sharing of information by councils will be required in order to improve transparency. This will involve identifying who should be the principal users of information and how they can best access it.

Recommendations:

- WHO should review definitions of transparency and disclosure with the aim of identifying operational objectives and processes that can improve targeting and use of information in future programmes. This should also include consideration of the aims and objectives of dissemination of information to the general public and sub-groups such as patient groups.

- WHO should provide guidance for councils to ensure that information on council work is effectively fed back to the constituencies of the different council members.
- WHO should include this topic in new planning and implementation guidelines (see above), including developing monitoring indicators.

Accountability and governance

There is a lack of evidence to establish causative links between increased transparency and accountability. It is a significant programme weakness that will require further work.

Recommendations:

- WHO should review experiences and findings, including from other sectors, with the aims of (a) clarifying definitions of both transparency and accountability and (b) identifying effective processes that lead to improved accountability
- WHO should also strengthen MeTA methodology in order to (a) identify the specific objectives, roles and functions to be pursued by each sector in meeting the collective council aims; and (b) specify good governance standards and tools, including **written constitutions/internal rules** for formal adoption by councils.

Improving the outcome of policy dialogue

The term "policy dialogue" was used loosely and included dialogue with stakeholders who were not policy makers but may be influential in promoting change in both medicines policy as well as business practice.

Recommendation:

- WHO should clarify the definition of policy dialogue in order to specify its intent and the processes through which it can promote changes in both policy and practice in line with council objectives and work plans. The roles and functions of the private sector have been neglected and therefore require particular attention.

Sustainability

Countries have been obliged to prepare sustainability plans at a very late stage of the programme and we have found that financial sustainability seems far from assured in most countries. CSO survival is probably most at risk and warrants high priority in view of their potentially critical contribution to the process of good governance.

Recommendations:

- As a matter of urgency, WHO should consult with governments in participating countries in order to confirm the importance they attach to the continued existence of each national council and the ways in which Ministries of Health can assist them to continue their work. Special attention will be required to assure the means for continuing CSO participation.
- WHO should develop and include sustainability indicators in monitoring tools to be used in future programme reviews. These should institutional sustainability in terms of integration

of national councils within pharmaceutical governance institutions in each country as well as their capacities for financial viability.

- WHO should provide strong oversight in order to avoid the risk that fund-raising, including integration into wider donor-funded projects, could serve to blur councils' visibility and their roles in improving transparency and governance in the national pharmaceutical systems in their entirety.

9.2 Future WHO technical and managerial support for national councils and health authorities

Respecting a country-specific approach

Phase II has demonstrated that councils can successfully pursue a country-specific agenda in comparison with the standardised approach imposed in the Pilot Phase. To that extent MeTA has evolved from a global programme with country components to become a much more county-specific programme that benefits from global technical support. Nevertheless Phase II administrative back-up has remained standardised and top-down.

Recommendations:

- In the event that WHO chooses to promote the MeTA model in other countries in future, the principal aim should be to support the creation of strong national forums and to avoid a top-down, overly standardised, global programme approach.
- WHO should develop new guidelines on how support will be provided to councils, specifying the roles to be played by its country, regional and HQ levels. Guidelines should include commitment to robust financial support including timely release of funds, avoidance of funding gaps and rules of procedure that can cope with short-term financial support.

Creating unified management structure

Whilst IMS effectiveness in Phase II has surpassed Pilot Phase performance, the management structure has remained split despite strong recommendations to establish a unified structure under one direction. WHO global, regional and country structure will not guarantee streamlined management in future.

Recommendations:

- WHO should develop a management strategy to guide its future work on transparency and governance in order to clearly define the responsibilities, roles and functions to be assigned to country, regional and headquarter levels
- Based on its strategy WHO should include a negotiation process with the Ministry of Health in each country wishing to establish a MeTA-style national council in order to clarify and formally agree details of technical and administrative responsibilities and functions to be adopted by each party.

Ensuring strong technical support to councils and countries

Phase II has further revealed the complexities involved in creating and strengthening the capacities and performance of multi-stakeholder councils. In addition to councils themselves, the crucial

importance of strong government endorsement and engagement have been confirmed. Future success will require both timely access to technical support in countries as well as a facility for inter-country learning and research.

Recommendations:

- WHO should ensure dedicated technical support to councils by continuing to establish posts for medicines experts in country offices e.g. National Professional Officers
- WHO should make provision for inter-country learning, for example, through annual global meetings and financial support to facilitate participation by selected council members in technical meetings
- WHO should establish a research component to its governance activities as a means of increasing knowledge and understanding on both the concepts and operational implications of transparency, accountability and good governance in the pharmaceutical sector. The roles of the private sector and CSOs warrant particular attention.

9.3 Is the MeTA approach at country level something that WHO should invest in?

WHO's longstanding roles and functions in countries include the provision of technical support and serving as a special 'trusted' advisor to the Ministry of Health as well as participating in policy dialogue. WHO is not an implementing agency per se.

The recently adopted Sustainable Development Goals are intended to give renewed urgency, impetus and direction to global development efforts. Improving access to essential medicines has been included as one important element.

WHO has already made significant technical, managerial and financial investments in the achievements of MeTA Phase II. WHO has also invested in other programmes whose principal objectives are transparency and good governance i.e. Good Governance in Medicines. In other words WHO has accumulated the experience necessary to drive a programme that includes the MeTA approach although its capacities remain limited.

At the same time there is increased interest within WHO to include transparency and good governance in its work aimed at strengthening health systems, including pharmaceutical systems.

Recommendations:

- WHO should adopt and integrate a MeTA approach within its wider work on strengthening transparency and good government in medicines. This should be done in full recognition of the need to correct current weaknesses in capacities and expertise, especially in country offices, as noted in section 9.3 above.
- As recommended in 9.3 WHO should develop a management strategy that recognises WHO's constitutional obligation to cooperate with Ministries of Health. The strategy should include (a) building Ministry of Health capacities both to engage with councils as well as ensuring oversight and (b) identifying how CSOs and the private sector representatives can achieve capacities to fulfil their respective roles in council business.

9.4 What would countries need to run such a programme?

Based on lessons learnt in Phase II, Section 9.2 includes recommendations on improving national council capacities and performance. In summary, countries would need

- Promotion for and acceptance of the approach (new countries)
- Training in the principles of MeTA (multi-stakeholder principles, transparency, accountability, etc.)
- Guidelines on how to implement the approach (partially available)
- Funds to run a (part-time) secretariat / coordinator
- Continued capacity building for CSOs

9.5 What strategic lessons have been learnt that may require a strategic approach on behalf of WHO rather than a "technical fix"?

1. Little willingness to change was noted on the part of the private sector, although understanding of the challenges of improving access to medicines may have been improved. Indeed most resistance came from the private sector, for example in dialogue related to pricing policies, ethical promotion of medicines.

Recommendation:

- WHO should strengthen MeTA methodology in order to identify the specific objectives, roles and functions to be pursued by each sector, particularly the private sector, in meeting the collective council aims and objectives (see 9.2 above). This information should be used to build consensus in councils on expected behaviour change and included in indicators for transparent monitoring of council performance.

2. CSO sector needs continuing capacity building to engage technically in general access to medicines issues.

Recommendation:

- WHO should develop appropriate CSO training materials and include budget support for regular capacity training in-country as well as inter-country learning

3. Ministries of Health commit to MeTA principles, but often are weak and irregular council participants

Recommendation:

- WHO should recognize that Ministries of Health are key actors and their endorsement, support and engagement will be key determinants of the success of future programmes. As recommended in 9.3 above, WHO should develop a management strategy that targets Ministries of Health capacities and behaviour. Table 9 includes lessons that relate to improving council performance, including Ministry of Health engagement.

4. Documentation of MeTA successes, achievements and failures is inadequate. More process information is needed.

Recommendations:

- As recommended in 9.2 above WHO should use the lessons learnt from Phase II to prepare new basic principles and operational guidelines to promote the MeTA approach. In order to achieve this objective guidelines necessarily must feature processes and address the questions "what was done" and "how it was done".
- WHO/EMP should share copies of the recently prepared "MeTA country brochures" as a step in promoting dialogue on MeTA implementation and process topics

5. The MeTA approach can provide a push to achieve reforms but is rarely the only player. There needs to be more cooperation with other relevant players.

Recommendations:

- WHO guidelines on transparency and good governance should feature the MeTA approach as one tool amongst others. Its selection and application in specific countries should be dependent on a situation and problem analysis and agreement on the strategic opportunities and impact that might evolve from the creation of a national multi-stakeholder forum. The subsequent planning process should situate the MeTA approach within the bigger picture of efforts to reform medicines policies and practices including budget frameworks in keeping with the Paris Principles.
- The subsequent implementation programme should include periodic joint reviews of progress and identify changes needed to ensure complementarity.

9.6 Principal conclusion

MeTA has been successful in achieving its aims. The key determinants of success are the capacities of national councils and the quality of technical support they can access. The performance and impact achieved by most countries surpassed the expected log frame outcomes and outputs. In other words national councils have been able to perform better than expected.

Recommendations:

- WHO should use the experiences and lessons learnt from MeTA to promote the roles of multi-sectoral councils as key drivers of change in national medicines policies, particularly their roles in promoting transparency, accountability and policy dialogue.
- WHO should consider integrating a MeTA approach into its wider work on transparency and good governance in medicines.

ANNEXES

9.7 Annex 1. Terms of Reference

Medicines Transparency Alliance Initiative

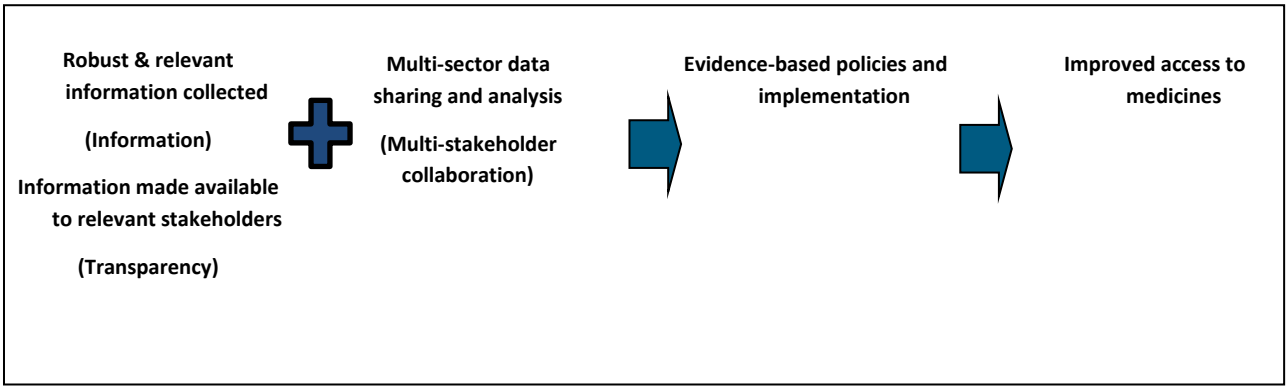
WHO Programme Evaluation: Terms of Reference

Background

More than two billion people lack reliable access to essential medicines in the developing world. (i) Average availability of medicines in public sector facilities in developing countries is low, often forcing people to purchase medicines in the private sector where availability is high, but prices are unaffordable. (ii)

Inefficient public and private markets and poorly functioning supply chains restrict the access of the poor to affordable, quality and appropriate medicines. Lack of information and information asymmetries (e.g. between manufacturers, wholesalers, retailers and consumers) fuel inefficiencies, distort competition, allow corrupt practice, hinder effective management and encourage irrational use of medicines. Furthermore, the poor often suffer disproportionately from inefficiency and low quality products and services in the pharmaceutical sector. (iii)

The Medicines Transparency Alliance (MeTA), funded by the UK Department for International Development (DfID), aims to contribute to improved access to quality essential medicines by increasing transparency in the pharmaceutical sector through multi-stakeholder collaboration, with a particular focus on price, availability, and quality (which map directly to the areas identified by WHO, where large efficiencies can be made). The theory of change underpinning MeTA may be depicted as follows:



For example, it is expected that investments in transparent processes for collecting and analysing data about the availability and price of quality assured medicines will provide information that demonstrates where availability is lower than expected or where prices are higher. This in turn, if shared with an organised group of selected stakeholders involved in pharmaceutical policies that includes relevant representatives of the Ministry of Health (MoH) and of other national public health institutions of the private sector and civil society, will provide an opportunity to influence development and implementation of appropriate policies to increase access to medicines. The relative strengths of the different groups in this process, broadly speaking, are the policy making, dissemination and enforcement abilities of the MoH and national public health institutions; the

ability of the private sector to influence prices and improve supply chains; and the capacity of civil society to voice concerns and raise questions. The implementation of these improved policies should result in a notable improvement in the efficiency of the medicines supply chain, observed through the availability of quality essential medicines at lower prices (as required).

More information on MeTA can be found on the following sites:
http://www.who.int/medicines/areas/coordination/meta/en/ ,
http://www.medicinestransparency.org/

Purpose and scope of MeTA Programme evaluation

The overall objective of the MeTA evaluation is to provide the WHO EMP Department and DfID with sufficient information about MeTA's achievements, challenges and for informing WHO strategy for future work in transparency and good governance in the pharmaceutical sector on countries.

Objectives

- To determine whether MeTA's objectives were relevant and realistic. The degree to which the project addresses the needs of beneficiaries and other stakeholders;
- To identify key successes/strengths/outcomes of MeTA at global and country level;
- To identify barriers/difficulties at global level and in countries when implementing MeTA projects;
- To assess achievements in the pharmaceutical sector in Phase II countries - the evaluation criteria should include relevance, efficiency, and effectiveness of the MeTA initiative;
- To document lessons learned and possible catalytic effects of the programme;
- To identify synergies with other programmes/work on good governance and transparency in countries that are relevant and have a potential impact for improving access to medicines;
- To assess the degree to which activities were compatible with governmental and stakeholders policies and to what extent those activities are being appropriated and internalized by beneficiaries;
- To assess whether the activities were sustainable;
- To give recommendations on how lesson learnt from MeTA can best contribute to future WHO work in transparency and good governance in the pharmaceutical sector;
- To explore the vision of key partners and donors involved in medicines policies for improving transparency and good governance of the pharmaceutical sector and their interest and needs for collaboration with WHO.

Scope

In achieving the objectives of the MeTA programme evaluation, the consultants should consider:

- Programme design and Implementation by WHO:
    - Effectiveness and relevance of the project design (targets, indicators);
    - Implementation methodology employed by WHO including the quality of management and reporting;
    - Any delays in the starting up of projects activities at country level and any adjustments or corrective measures in terms of time and activities to catch up with possible delays;

    - The degree of achievement of the programme in relation to its original purposes and expected results, institutional framework and expenditure patterns;
    - The main constraints and possible solutions.
- The degree of coherence of the programme with national medicines policies and implementation plans at governmental level and activities undertaken by other stakeholders.
- The degree of co-ordination and complementarities of project's activities with other WHO activities at country and global levels.
- The prospects for sustainability of project benefits. This includes inter alia capacity building, local ownership, and integration of the project's activities into national plans and stakeholders programmes.

Methodology and approach

- Desk top review of MeTA background documents (e.g. progress reports, meeting reports, publications, tools);
- Development of a questionnaire to be sent to all MeTA countries;
- Face to face and telephone interviews with a list of key actors in MeTA at global and country level (EMP coordinators, MeTA coordinators, members of the MeTA technical working group, WHO Regional advisers for medicines, WHO National Professional Officers, MeTA focal points in countries, representatives of Ministry of Health, donor representatives);
- Country visits as needed to meet with key policy makers, MeTA focal points, members of MeTA task forces and steering committees, WHO NPOs and representatives;

Required Results

- A full evaluation report including final recommendations and an executive summary which will be made publicly available.

Timing of Outputs

- The evaluation will run upon completion of Phase II of the MeTA initiative (end December 2015).
- A final report of findings should be submitted by 31 December 2015.

Skills and qualifications

Demonstrable experience of delivering quality evaluations will be required. The use of local consultants in the MeTA countries could be considered.

The evaluators will have:

- Extensive experience in conducting programme evaluations using qualitative and quantitative methods, particularly in the health sector
- Experience of evaluating medicines policy development and supply chains
- Experience of evaluating governance and/or transparency and accountability programmes
- Strong research and analytical skills
- Critical interviewing skills
- Knowledge of governance, management, health economics, civil society and private sector pharmaceutical institutions
- Knowledge and understanding of the different challenges and impacts of access to health services and products for different socioeconomic groups

- Previous experience in the MeTA countries is an asset.

Selection of the evaluator will take place by October 2015, at which time meetings will be arranged with WHO and HAI to discuss in detail the most appropriate evaluation methodologies and next steps.

Annexes

- Intervention Summary (Business Case)
- MeTA logframe

(i) WHO (2004). World Medicines Situation Report

(ii) MDG Gap Taskforce Report (2008). "Delivering on the Global Partnership for Achieving he Millennium Development Goals"

(iii) Cohen JC, Mrazek M, Hawkins L. Corruption and pharmaceuticals: Strengthening good governance. In: Campos JE, Pradhan S, eds. The many faces of corruption: Tracking corruption at the sectoral level. Washington, D.C., World Bank Publications, 2007:30.

9.8 Annex 2. Questionnaires for provision of written feed-back

1. QUESTIONNAIRE TO SELECTED INDIVIDUALS IN COUNTRIES

The purpose of this questionnaire is to learn lessons from country experiences of the MeTA programme in order to guide and inform possible future WHO work in strengthening transparency and good governance as a means of increasing access to essential medicines.

It is addressed to selected experts in each MeTA participating country in order to seek their individual observations and opinions. The information provided will form part of a review of MeTA Phase II conducted on behalf of WHO.

Q.1 In your opinion did the MeTA programme in your country achieve what it set out to achieve? What were the principal achievements? What were the principal obstacles and/or failures? Please give reasons for your opinions.

Q.2 Was the multisectoral council effective:

- In achieving participation by the most relevant representatives of government, the private sector and civil society? Were any important stakeholders not represented?
- In focusing attention on those issues most relevant to improving transparency and improving policy and business practice with regard to improved access to essential medicines? Please give examples.
- In promoting changes in national pharmaceutical policies and the business practices of the private sector? Please give examples.

Q.3 In your opinion did the representatives of each group of members (government institutions, the private sector, civil society) contribute effectively to the discussion and work programme of the forum (did they do what they were supposed to do)? Please provide some examples of positive contributions that were made. How could they have contributed more effectively?

Q.4 Were there any serious problems that undermined the proper functioning of the council e.g. management of meetings, secretariat support, financial difficulties, disagreements between participants? Please give examples and suggest how they could have been avoided.

Q.5 Did the representatives of each group feedback information and council recommendations to their respective "constituents" in order to improve transparency and facilitate changes in policy and business practice? Please give examples of actions taken by each of the three groups.

Q.6 How did the council communicate its information and recommendations to the general public? What did the civil society representatives do in this regard? What effects/changes did this achieve with regard to improving access to essential medicines?

Q.7 What roles were played by the IMS (HAI and WHO) in supporting the work of the council? Were they effective? What could they have done better? Please give reasons for your opinions.

Q.8 In your opinion was the design of the MeTA programme properly suited to the specific needs and situation in your country or was it too standardized and top-down?

Q.9 In your opinion, did the MeTA programme in your country benefit from the fact that MeTA was a global programme that was also implemented in other countries? Please provide examples.

Q.10 In your opinion how has the MeTA programme benefited your country?

Q.11 Is the MeTA multi-stakeholder approach something that WHO should support in the future?

2. QUESTIONNAIRE TO IMS (HAI and WHO)

A. QUESTIONS TO HAI and WHO

1. Did the Pilot Evaluation findings inform the design, structure, administrative and technical content, and governance arrangements for Phase 11? Please give examples.
2. What changes were made in Management arrangements for Phase II by DFID:
   - With regard to IMS structure, roles and functions?
   - What happened to MeTA Management Board and International Advisory Group?
   - Who was appointed overall programme manager/accountable?
   - With regard to IMS, what were definitions of "administrative" and "technical" functions and actions?
3. What was the purpose of the Project Management Agreement? When was it signed? Were countries informed of its content – specifically Functions and Responsibilities of MeTA national councils and the respective roles and functions of HAI and WHO?
4. Did government/MoH in all countries sign a formal commitment to participation in MeTA Phase II?
5. What was the total DFID budget for MeTA Phase II? What were the amounts and purposes of budget allocated to HAI and WHO respectively? How were funds channelled to countries? Were additional funds provided to countries by HAI and/or WHO? If so, how much and for what purpose? Were additional in-kind resources provided to support countries e.g. WHO technical support and HAI support to CSO capacity building? Please specify.
6. Did all councils have formal written rules and standards, especially to ensure transparency and ethical behaviour? Please provide examples.
7. How were members briefed and prepared for their roles within each MeTA national council? Were specific measures taken to address possible suspicions and build trust between the public, private and CSO sectors?
8. What measures were taken to define the specific roles and inputs to be provided by private sector members?
9. How did HAI and WHO prepare for cooperation with private sector representatives in view of their limited experience in this regard?
10. How did councils distinguish between achievements that resulted from actions taken by individual members in the course of their "normal" work and those taken on behalf of MeTA e.g. membership of working groups advising government on NMP?
11. Did the delay in Phase II start-up have any impact on MeTA activities in countries? Please give examples. What processes were undertaken in order to revive MeTA in countries?
12. Who was responsible to keep the global MeTA website up-to-date? What was the reason that the MeTA website update has been very limited?

13. What specific actions were taken with regard to “sharing of information and knowledge” – within countries, between countries, globally? Please give examples.

B. ADDITIONAL QUESTIONS TO HAI

1. What activities did HAI undertake to promote “effective functioning of national councils””? Please give examples.
2. What processes and activities did HAI undertake in order to strengthen CSO capacities to participate in the MeTA programme? Please specify any cross country learning processes that were undertaken.
3. Did HAI encounter any difficulties in fulfilling its roles and functions in implementing MeTA Phase II? Please specific and suggest how they could have been avoided.

C. ADDITIONAL QUESTIONS TO WHO

1. What activities did WHO undertake in order to provide technical guidance and support to MeTA national councils? Who provided the support (Country Office, RO, HQ)?
2. How were WHO staff prepared/trained to play their roles in technical support to MeTA? Were these activities partially or totally funded by MeTA?
3. Please list WHO tools and guidelines that were used to provide technical support to MeTA national councils. Did WHO develop any tools and guidelines specifically for MeTA? Please specify.

9.9 Annex 3. Summary of written feed-back from countries

In the table below column headers specify the stakeholder group and the total number of responses received from each stakeholder group. Not more than one response from each stakeholder group was received per country.

		CSO (3)	GOV (3)	PRIVATE (2)	WHO CO (4)	MeTA Coord. (5)	WHO Cons. (1)	Other (1)	Total (19)
1	**Did the MeTA programme in your country achieve what it set out to achieve?**								
	Yes	2	1	2	2	3	1	0	**11**
	Impact on availability & affordability not yet proven	0	0	0	0	1	0	0	**1**
	Achievement: awareness of MeTA (& transparency / accountability)	0	0	0	1	0	0	0	**1**
	Achievement: training manual on MeTA	1	0	0	0	0	0	0	**1**
	Achievement: bringing CSO on the table	1	1	0	1	2	0	0	**5**
	Achievement: CSO capacity building	1	0	0	0	1	0	0	**2**
	Achievement: CSO monitoring of medicines availability	0	1	0	0	0	0	0	**1**
	Achievement: better representation on private sector	0	0	1	0	0	0	0	**1**
	Achievement: multistakeholder platform	0	2	2	2	5	1	0	**12**
	Achievement: trust among stakeholders	0	0	0	1	0	0	0	**1**
	Achievement: democratic decision making if opinions differed	0	1	0	0	0	0	0	**1**
	Achievement: policy dialogue	0	0	0	1	2	0	1	**4**
	Achievement: MeTA providing needed push to government to engage in reforms	0	0	1	1	0	0	0	**2**
	Achievement: policy development /revisions	1	3	0	3	1	1	0	**9**
	Achievement: section on transparency in policy	0	0	0	1	1	0	0	**2**
	Achievement: law amendments	0	1	0	2	1	1	1	**6**
	Achievement: increased transparency through observatories (quality, price, availability)	0	1	0	0	0	0	0	**1**
	Achievement: putting sensitive issues (e.g. compulsory licensing) on the public agenda	0	1	0	0	0	0	0	**1**
	Achievement: public sector capacity building	0	0	0	1	0	0	0	**1**

		CSO (3)	GOV (3)	PRIVATE (2)	WHO CO (4)	MeTA Coord. (5)	WHO Cons. (1)	Other (1)	Total (19)
	Achievement: software & tools for public procurement	0	0	0	1	0	0	0	**1**
	Achievement: local manufacturers are now receiving contracts for government tenders	0	0	1	0	0	0	1	**2**
	Achievement: work on promotion & supply chain management	0	0	0	0	1	0	0	**1**
	Obstacle: - Highly politicized topic actively discussed in mass media push politicians to hasty decisions	0	0	0	1	0	0	0	**1**
	Obstacle: slow performance, council not well informed	1	0	0	0	0	0	0	**1**
	Obstacle: weak participation public & private sectors	0	1	0	0	0	0	0	**1**
	Obstacle: change in individuals representing institutions on council	0	1	0	0	0	0	0	**1**
	Obstacle: lack of commitment MOH	0	0	1	0	0	0	0	**1**
	Failure: insufficient presence of MeTA in overall public health policy agenda	0	1	0	0	0	0	0	**1**
	Obstacle: private sector depending on regulatory authority	0	0	0	0	1	0	0	**1**
	Obstacle: No champions for ensuring that recommendations are taken up	0	0	0	0	1	0	0	**1**
	Obstacle: no platform for dissemination of information	0	0	0	0	1	0	0	**1**
	Obstacle: MRA did not accept MOH taking lead in policy reform with multi stakeholder approach	0	0	0	0	1	0	0	**1**
	Obstacle: delayed start of implementation	0	0	0	1	2	0	0	**3**
	Obstacle: premature ending of programme	0	1	0	1	2	0	0	**4**
	Obstacle: uncertain funding	1	0	0	1	0	0	0	**2**
	Obstacle: inadequate funding	0	0	0	0	0	0	1	**1**
	Obstacle: high turn-over of senior staff / changes in leadership	0	0	0	1	1	0	0	**2**
	Obstacle: Syrian refugee crisis	0	0	0	1	0	0	0	**1**
	public sector participation depending on position in public sector	0	0	0	0	1	0	0	**1**
2	**Was the multisectoral council effective**								
	Yes, effective	1	1	0	3	4	0	1	**10**
	Yes, partially effective	1	0	0	0	0	1		**2**

		CSO (3)	GOV (3)	PRIVATE (2)	WHO CO (4)	MeTA Coord. (5)	WHO Cons. (1)	Other (1)	Total (19)
	All important stakeholders represented	1	2	1	3	5	1	1	**14**
	Provided platform for engagement private sector with government & the public	0	0	0	0	1	0	0	**1**
	Marginal participation by some stakeholders	0	0	0	0	0	0	1	**1**
	Weak participation public sector	0	1	1	0	0	0	0	**2**
	Weak participation private sector	0	1	1	1	1	0	0	**4**
	More CSO representation would be better	0	0	0	1	0	0	0	**1**
	General practitioners invited but declined; council should have pushed them more	0	0	1	0	0	0	0	**1**
	Academia not interested; some stakeholders did not participate in meetings during last year	0	1	0	0	0	0	0	**1**
	Additional representatives (e.g. other donors) would have been good, but then council would have been too large	0	0	0	0	1	0	0	**1**
	Patient groups joined late	0	0	0	1	1	0	0	**2**
	Focus was on most relevant issues	2	3	1	4	4	1	0	**15**
	Strong Government support	1	0	0	0	0	0	0	**1**
	Media not represented	1	0	0	0	0	0	0	**1**
	No impact on policy implementation & legal reviews	1	0	0	0	0	0	0	**1**
	Failure: new policy has no changes related to medicines pricing	0	0	1	0	0	0	0	**1**
	Insufficient interaction with actual policy drivers	0	0	0	0	0	0	1	**1**
	New policy includes principles on GxP	0	0	0	1	0	0	0	**1**
	No effect on business practices	1	0	0	0	0	0	0	**1**
3	**Did the representatives of each group of members contribute effectively to the discussion and work programme**								
	Yes	3	3	2	4	5	1	1	**19**
	Through active participation in working groups	0	1	0	0	0	0	0	**1**
	Through facilitating access to key stakeholders (in government, CSO sector)	0	0	0	0	1	0	0	**1**
	With different levels of activity depending on sector interest	0	0	0	1	0	0	0	**1**

		CSO (3)	GOV (3)	PRIVATE (2)	WHO CO (4)	MeTA Coord. (5)	WHO Cons. (1)	Other (1)	Total (19)
	CSO representation should have been stronger from the beginning	1	0	0	0	0	0	0	**1**
	Private sector s/t resisted proposed changes	1	0	0	0	0	0	0	**1**
	Insufficient government commitment	0	0	1	0	0	0	0	**1**
	MRA no active participation	0	0	0	0	1	1	0	**2**
	CSO benefited from capacity building	0	1	0	0	0	0	0	**1**
	domestic industry erratic participation (multi-nationals regular)	0	0	0	0	1	0	0	**1**
	work was done separately by different sectors, not as a collective	1	0	0	0	0	0	0	**1**
4	**Were there any serious problems that undermined the proper functioning of the council**								
	No	1	1	1	3	3	1	1	**11**
	Weak secretariat with staff not allocating sufficient time	1	0	0	0	0	0	0	**1**
	No technical capacity in Secretariat	0	0	1	0	0	0	0	**1**
	coordinator had to do administrative tasks (no admin staff)	0	1	0	0	0	0	0	**1**
	Secretariat not effective to ensure regular participation in meetings or convince additional stakeholders	0	1	1	0	0	0	0	**2**
	No physical office	1	0	0	0	0	0	0	**1**
	Admin subcommittee did not meet	0	0	0	1	0	0	0	**1**
	members did not always state conflict of interest	0	0	1	0	0	0	0	**1**
	No trust Council - CSO	1	0	0	0	0	0	0	**1**
	No trust Council - MRA	0	0	0	0	1	0	0	**1**
	Funds for CSO not released by council	1	0	0	0	0	0	0	**1**
	Disagreement between council members	1	0	0	0	0	0	0	**1**
	CSO very active & public sector avoided contact with CSO	0	1	0	0	0	0	0	**1**
	Irregular participation at council meetings	0	0	0	0	1	0	0	**1**
	Council members too busy with other work*	1	0	0	0	1	1	0	**3**
	Stronger commitment from MOH needed to increase other stakeholders' commitment	0	0	0	0	1	0	0	**1**

		CSO (3)	GOV (3)	PRIVATE (2)	WHO CO (4)	MeTA Coord. (5)	WHO Cons. (1)	Other (1)	Total (19)
	Work plan not followed	1	0	0	0	0	0	0	**1**
	limited financial resources	0	0	0	0	1	0	0	**1**
	CSO were not involved in budget discussions & financial management - internal MeTA processes lacked transparency	1	0	0	0	0	0	0	**1**
5	**Did the representatives of each group feedback information and council recommendations to their respective "constituents"**								
	Yes, mostly	1	2	0	1	3	0	1	**8**
	Did their best	0	0	0	0	1	0	0	**1**
	Difficult to say for all agencies involved	0	0	0	0	1	0	0	**1**
	Information did not always reach decision makers or 'trickled down'	0	0	0	0	1	0	0	**1**
	Weak flow of information from national to district level	1	0	0	0	0	0	0	**1**
	dynamic feedback loop (back from constituencies to working groups/council)	0	1	0	0	0	0	0	**1**
	Private sector round tables	0	1	0	0	1	0	0	**2**
	Private sector through associations & 'MeTA talks' during meetings	0	0	2	1	1	0	1	**5**
	Private sector fragmented / competing associations	0	0	0	0	0	1	0	**1**
	public sector as per internal procedures	0	0	0	0	0	1	0	**1**
	through websites	0	0	0	0	1	0	0	**1**
	CSO through forums, dialogues, workshops	1	0	0	1	0	0	0	**2**
6	**How did the council communicate its information and recommendations to the general public?**								
	Communication to grass root level needs to be improved	1	0	0	0	0	0	0	**1**
	CSO did workshops / media campaigns	1	0	1	0	1	0	0	**3**
	through websites, social media	0	2	1	4	2	1	1	**11**
	CSO: public awareness campaigns	0	2	0	0	1	0	0	**3**
	Campaign helped to improve use of antibiotics	0	0	0	0	1	0	0	**1**
	Round tables, discussion series	0	0	0	2	1	1	0	**4**
	Council meetings	0	0	0	0	1	0	0	**1**

		CSO (3)	GOV (3)	PRIVATE (2)	WHO CO (4)	MeTA Coord. (5)	WHO Cons. (1)	Other (1)	Total (19)
	Stakeholder forums	0	1	1	2	2	0	0	**6**
	letters to MOH	0	0	0	1	0	0	0	**1**
	Print media	0	1	0	1	1	0	1	**4**
	Newsletters	0	0	1	0	0	0	0	**1**
	radio shows	0	0	1	0	1	0	1	**3**
	Mailing lists	0	0	0	1	0	0	0	**1**
	communication was very effective; the public has been sensitised	0	1	1	0	0	0	1	**3**
	Helped to create awareness on critical issues that need to be addressed	0	0	0	0	1	0	0	**1**
7	**What roles were played by the IMS (HAI and WHO) in supporting the work of the council?**								
	IMS effective / supportive	2	3	2	3	3	1	1	**15**
	IMS provided technical & administrative support	0	0	0	0	1	0	0	**1**
	WHO provided technical support	1	0	0	1	1	1	1	**5**
	WHO hosted meetings	1	0	1	0	0	0	0	**2**
	MeTA was seen as WHO baby	1	0	0	0	0	0	0	**1**
	HAI support to secretariat and CSO	0	0	0	0	1	1	0	**2**
	HAI capacity building support important (training, TA)	2	0	0	0	1	0	0	**3**
	HAI suggestions were not implemented by council	1	0	0	0	0	0	0	**1**
	IMS important to keep implementation on track	0	0	1	0	0	0	0	**1**
	IMS provided information from other countries	0	0	1	0	0	0	1	**2**
	IMS should have supported CSO separately	1	0	0	0	0	0	0	**1**
	More technical support for committees (training / materials) needed	0	1	0	0	0	0	0	**1**
	Progress on technical work only possible once focal person was available in WHO CO (mid 2014) - about 1 1/2 years were lost	0	0	0	0	1	0	0	**1**
	MeTA global website is not updated	0	0	0	0	1	0	0	**1**
	IMS should have provided communication/information material on MeTA to all countries	0	0	0	0	1	0	0	**1**
	IMS should have published all MeTA studies	0	0	0	0	1	0	0	**1**

		CSO (3)	GOV (3)	PRIVATE (2)	WHO CO (4)	MeTA Coord. (5)	WHO Cons. (1)	Other (1)	Total (19)
	IMS should provide continuous funding to allow longer term planning	1	0	0	0	0	0	0	**1**
	Inefficient (delayed) release of funds	0	1	2	1	2	0	1	**7**
8	**was the design of the MeTA programme properly suited to the specific needs and situation in your country or was it too standardized and top-down**								
	too standardised/top down	2	0	1	0	0	0	0	**3**
	suited to the needs	2	3	1	3	5	1	1	**16**
	more flexibility in Phase II	0	1	0	0	0	0	0	**1**
	Component for media was missing	1	0	0	0	0	0	0	**1**
	Lack of MOU with MOH in phase 2 put secretariat under risk for sensitive issues	0	0	0	0	0	1	0	**1**
	inadequate resources for additional MeTA work at WHO CO	0	0	0	1	0	0	0	**1**
	pilot phase better in terms of funding & management	0	0	1	0	0	0	0	**1**
	Should have been situated in MOH	0	0	0	1	0	0	0	**1**
9	**did the MeTA programme in your country benefit from the fact that MeTA was a global programme**								
	Yes	1	1	2	2	2	0	1	**9**
	No	1	1	0	0	1	0	0	**3**
	In the pilot phase only	0	0	0	0	1	0	0	**1**
	In phase 2 there was no 'global MeTA brand' visible	0	0	0	0	1	0	0	**1**
	Jordan officials inspired by Philippines	1	0	0	0	0	0	0	**1**
	TC between Jordan and KYR on policy review	0	0	0	1	0	0	0	**1**
	country comparisons added value & incentives (competition)	0	1	2	2	1	0	0	**6**
	could have benefited more / more sharing of experiences needed	1	1	0	0	0	0	0	**2**
	Could be helpful if MeTA was a 'mandatory' global programme	0	0	0	0	0	1	0	**1**
	IMS should have done much more to promote exchange of experiences (a formal platform, exchange visits, global meetings)	0	0	1	0	1	0	1	**3**
	The Global Meeting 2014 was too late	0	0	0	1	1	0	0	**2**

		CSO (3)	GOV (3)	PRIVATE (2)	WHO CO (4)	MeTA Coord. (5)	WHO Cons. (1)	Other (1)	Total (19)
	Learned from other countries (e.g. Peru, Uganda)	0	0	0	0	1	0	0	**1**
10	**how has the MeTA programme benefited your country**								
	enhanced transparency	1	1	1	2	0	0	0	**5**
	enhanced transparency & accountability (prices, availability, quality)	0	1	0	0	0	0	0	**1**
	legitimised involvement of CSO in policy setting and implementation	1	2	0	1	1	0	0	**5**
	implementation of multi stakeholder approach	0	3	2	1	4	0	0	**10**
	greater awareness of good governance principles	0	1	0	0	1	0	0	**2**
	evidence based policy revisions	0	0	0	1	0	0	0	**1**
	will have long lasting effect	0	0	0	0	0	1	0	**1**
	changed peoples' minds	0	0	0	0	1	1	0	**2**
	providing funding for CSO capacity building	1	0	0	0	0	0	0	**1**
	constructive dialogues on medicines policy	0	0	0	1	1	0	0	**2**
	government adopted MS advisory process for medicine related issues	0	0	0	1	0	0	0	**1**
	Established image of strategic policy ally	0	0	0	0	1	0	0	**1**
	Sensitisation of public regarding quality issues & right to health	0	0	1	0	1	0	0	**2**
11	**Is the MeTA multi-stakeholder approach something that WHO should support in the future**								
	yes	3	3	2	4	5	1	1	**19**
	design to consider how to hold government accountable & how to effect policy reform	0	0	0	1	0	0	0	**1**
	design to be country specific	0	0	0	1	0	0	0	**1**
	CSO need more capacity building / support	1	0	0	0	0	0	0	**1**

MRA: Medicines Regulatory Authority

9.10 Annex 4: Bibliography

Project related documents – global level

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DFID Annual Reviews (2012, 2013, 2014, 2015)

Draft Project Collaboration Agreement to support the Medicines Transparency Alliance initiative (between HAI and WHO)

IMS 2014. *Outline of key messages, audiences and dissemination methods for MeTA countries* – Draft (to be completed)

IMS annual progress reports to DFID (2012, 2013, 2014, 2015) including Annexes

Medicines Transparency Alliance Programme (MeTA) Phase 2 Intervention Summary 2012 (DFID Business Case) including Annex A: MeTA Model, relevance to DFID priorities and pilot phase results

MeTA Pilot Phase and MeTA Phase II log frames

MeTA. *Administrative and budgetary guidance for submission of MeTA country work plans. Version 1.1*

MeTA. *Entry to the Medicines Transparency Alliance initiative: criteria and procedure*

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Ollier E, Gittins N, Collins T, Mubangizi P, Waddington C, Whitaker D, 2010. *Evaluation of the Medicines Transparency Alliance Phase 1 2008-2010*. DFID human development resource centre (hdrc)

Selected travel reports and project internal correspondences with countries

WHO, 2015. *Medicines Transparency Alliance Global Meeting 2014 – Meeting Synthesis.* WHO/EMP/PAU/2015.1

WHO/EMP. Comprehensive output tables (Outputs 2, 3 and 5) – achievement per country as per Year 4 (June 2015)

WHO/EMP. Progress report Output 2 (achievement per country as per year 4)

Project related documents – country level

(Semi-)Annual progress reports from countries including selected Annexes

Budgets for selected countries

Country work plans (narrative, plans of action, log frames)

Draft sustainability reports from MeTA Ghana, Jordan, Kyrgyzstan and Zambia

MeTA Global Meeting 2014 – Presentations from countries

Selected minutes of MeTA Council meetings

Selected reports from MeTA stakeholder forums and round table meetings held in countries

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