



**UNITAID**

**END OF PROJECT EVALUATION OF SUPPORT TO THE GLOBAL FUND  
TO FIGHT AIDS, TUBERCULOSIS AND MALARIA ROUND 6**

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**Report**

Submitted by:

**Cambridge Economic Policy Associates Ltd**

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## ACRONYMS

Acronym	Full description
ACT	Artemisinin-based Combination Therapies
AIDS	Acquired Immune Deficiency Syndrome
AMFm	Affordable Medicines Facility – malaria
ARV	Anti-retroviral treatment
CEPA	Cambridge Economic Policy Associates
CHAI	Clinton Health Access Initiative
DAC	Development Assistance Committee
EoP	End of Project
FPM	Fund Portfolio Managers
GDF	Global Drug Facility
HIV	Human Immunodeficiency Virus
LIC	Low income country
LMIC	Lower middle income country
MDR-TB	Multi-drug resistant Tuberculosis
M&E	Monitoring and Evaluation
MoU	Memorandum of Understanding
OECD	Organisation for Economic Cooperation and Development
OIG	Office of the Inspector General
PR	Principal Recipient
PRM	Price Reporting Mechanism
PQR	Price and Quality Reporting
PSM	Procurement and Supply chain Management
TRP	Technical Review Panel
UMIC	Upper middle income country
VPP	Voluntary Pooled Procurement

## EXECUTIVE SUMMARY

UNITAID's funding to the Global Fund for Round 6 was initiated and designed when the organisation was recently established. At this time, the Board was keen for UNITAID to develop a partnership with the Global Fund, as a key actor in the HIV/AIDS, TB and malaria sectors. UNITAID was also at a nascent stage in terms of its strategy and how it should design/ select projects to contribute to its objective of improving commodity markets to facilitate increased access and affordability. As a result, the project was not adequately designed, particularly in terms of affording price reductions on treatment drugs. The planned market mechanisms of pooled procurement and reference prices for the project were not considered in detail, contributing to their lack of implementation during the course of the project. In essence, the project was a earmarked contribution to the Global Fund to purchase treatment drugs as part of its country grants in Round 6, but the Global Fund lacked the necessary monitoring and accounting arrangements to be able to track the UNITAID contribution in a manner that would be useful for UNITAID, and allow it to ascertain the use and impact of its funds.

On the base of this weak design, the project has been poorly implemented, with considerably delayed timelines (more than double the original timescale); inadequate communication and collaboration between the two organisations; and lack of needed follow-up of issues identified during implementation. There have been diverging expectations from both organisations, stemming from a lack of clarity in the MoU as well as changes in focal points for the project (at both UNITAID and the Global Fund). Progress reporting by the Global Fund has been a key challenge for the project, not only because of the absence of any reporting to ascertain UNITAID's contribution, but also because of discrepancies and inconsistencies in the successive progress reports. As a result, the project has entailed considerably high transaction costs for both organisations.

Given these issues, the project has managed to expend only 51% of its allocation, resulting in its achievements in terms of number of people treated being considerably lower than planned (40% of the target). However the achievement is important with 4.6m people being provided with treatment through the contribution of the project. The number of people reached through the support of the project also contributed to approximately 34% of the total number of people treated/ cases reported between 2008-10 for the specific treatment niches. These results can be considered as additional as the Global Fund country grants were re-programmed to account for the UNITAID contribution. The focus on MDR-TB and 2<sup>nd</sup> line ARVs is also noted as an area of added value, given the low demand for these drugs at the time of the project origination. In terms of market impact however, given the issues with design and implementation, there is insufficient information to comment on any achievements.

In general, one of the key issues with the project was that it was set up as a contribution to Round 6 of the Global Fund – and in a sense therefore was considered in line with other donor funding by the Global Fund. Key lessons learnt and suggestions going forward are that UNITAID should adopt a more strategic and detailed approach to identifying and selecting projects for support; project

MoUs need to be sufficiently clear and detailed – but at the same time afford flexibility to facilitate implementation and encourage innovations; and it may be useful to adopt a ‘log of changes’ for a project to ensure any updates are adequately documented. It may also be useful to consider adopting a ‘light touch’ institutional mechanism for projects to improve ongoing collaboration as well as review progress.

## 1. INTRODUCTION

UNITAID has appointed Cambridge Economic Policy Associates (CEPA) to conduct an End of Project (EoP) evaluation of its support to the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) Round 6 (referred to as ‘the project’ in the report). This report is our second deliverable under the assignment and presents our evaluation findings, lessons learnt and recommendations.<sup>1 2</sup>

In this introduction section, we set out a brief description of the UNITAID contribution to Global Fund Round 6 (Section 1.1), the objectives and scope of the evaluation (Section 1.2) and the structure of the report (Section 1.3).

### 1.1. Background to the UNITAID contribution to Global Fund Round 6

In December 2007, UNITAID agreed to make a contribution of US\$52.5m to exclusively fund the purchase of treatment drugs for 43 grants in 38 countries under the Global Fund Round 6 Phase I.<sup>3</sup> The goal of UNITAID’s support was to scale-up access to drugs and positively impact market dynamics for HIV/AIDS, MDR-TB and malaria (collectively known as the ‘treatment niches’) with two objectives:

1. increase the number of patients accessing and receiving treatment in the treatment niches through the funding of Global Fund grants in Round 6 Phase I; and
2. support price reductions of high-quality drugs for these treatment niches in national treatment programmes through efforts to facilitate the use of a reference price mechanism and pooled procurement.

The funding was provided for a period of 2.5 years, with a planned closing date of June 2010. However, there were a number of delays, and following an extension in November 2010, the project closed in December 2012. At present, UNITAID and Global Fund are in discussion to determine the total amount that has been expended under the project.

### 1.2. Objectives of the End of Project evaluation

The objective of the EoP evaluation, as set out in the Request for Proposal (RfP), is to “assess the project under review and determine whether or not it met the objectives that form part of the agreement between UNITAID and the Implementer”.

In particular, following the guidance in the RfP and discussions with UNITAID, our understanding of the objectives and scope of the evaluation are as follows:<sup>4</sup>

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<sup>1</sup> The first deliverable was an Inception Report (26 July 2013) on our evaluation approach and methodology.

<sup>2</sup> The report benefits from input and review from Caroline Lynch and Beatriz Ayala-Ostrom (CEPA Associates).

<sup>3</sup> Round 6 was launched by the Global Fund in November 2006, with a total approved funding of US\$846m covering 63 countries. Phase I of the round covers the period 2008-10, which was also the original timeline of the project.

<sup>4</sup> The UNITAID EoP evaluations also require an assessment of whether the recommendations of a mid-term review have been implemented. However a mid-term review was not conducted for this project, given delays in implementation, and hence review aspect is not relevant.

- To assess whether the initial objectives set by UNITAID and the Global Fund for the project have been met, including an assessment of the project achievements and impact (specifically market and public health impact<sup>5</sup>).
- To review the extent to which the project has been:
  - *Relevant*: whether activities/ outputs of the project have been consistent with objectives/ expected outcomes; and how the project has contributed to UNITAID's goals.
  - *Effective*: whether the objectives have been achieved within the planned timeframe as well as factors affecting achievement/ non-achievement.
  - *Efficient*: whether the project structures have been conducive to collaborative working; if project management has worked well; and if the procurement model was well designed.
  - *Impactful*: whether it has been possible to attribute UNITAID funding to the products purchased and patients treated.
- To understand lessons learnt and provide recommendations for UNITAID funding to the Global Fund going forward.

### 1.3. Structure of the report

The report is structured as follows:

- Section 2 presents our evaluation framework and methods.
- Sections 3-5 present our evaluation findings on the three evaluation dimensions of design, implementation and results.
- Section 6 discusses our conclusions, lessons learnt and recommendations.

The report is supported by the following Annexes: Annex 1 is a bibliography; Annex 2 lists the consultees for this evaluation; Annex 3 presents an analysis of UNITAID's country eligibility criteria as applied to this project; Annex 4 presents some analysis on achievements against targets; Annex 5 lists the methodology and assumptions for our assessment of public health impact under the project; Annex 6 summarises the key points of the UNITAID Secretariat's review of the Global Fund progress reports; Annex 7 presents a summary of the UNITAID Executive Board's update on operations; and Annex 8 presents a summary of Secretariat notes on key points of concern on the project.

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<sup>5</sup> Market impact (intentional and unintentional) for the products provided under the project agreements; and public health impact for the beneficiaries of the medicines, diagnostics and related products provided through the project.

## 2. EVALUATION APPROACH AND METHODOLOGY

This section sets out our evaluation approach and methodology, including limitations.

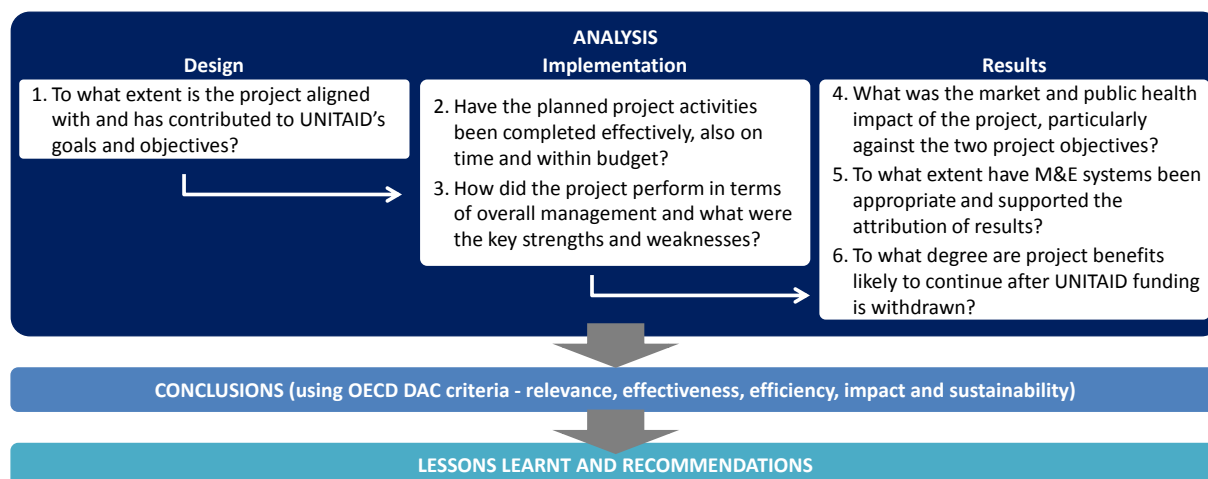
### 2.1. Evaluation framework

Following the objectives of the evaluation, and as set out in our Inception Report, we have structured the evaluation framework along three inter-related dimensions as follows (Figure 2.1):

- (i) **Design** – encompassing a review of the objectives and structure/ design of the project and its relevance in the context of UNITAID’s overall goals and objectives.
- (ii) **Implementation** – including an assessment of the efficacy of the activities conducted under the project (procurement mechanisms, timeliness, budgeting) as well as project management.
- (iii) **Results** – focusing on the impact of the project, comprising both market and public health impact as well as a review the M&E systems and processes and the sustainability of UNITAID funding.

Within each dimension, we have structured specific evaluation questions that facilitate a capture of key issues relevant for this evaluation. In our view, this framework considers the ‘chronological’ set of events from design to implementation and results, and together comprises a comprehensive assessment of the project.

Figure 2.1: Evaluation framework



Based on evidence collated on the evaluation questions, we summarise the main findings according to the Organisation for Economic Co-operation and Development’s (OECD) Development Assistance Committee (DAC) evaluation criteria (relevance, effectiveness, efficiency, impact and sustainability<sup>6</sup>). The strength of evaluation conclusions are based on an assessment of the quality (i.e. data quality, type of stakeholder group consulted for a particular evaluation question); and uniformity (i.e. triangulation) of the available evidence. This has been supplemented by our informed judgment on the interpretation of the evidence, drawing

<sup>6</sup> <http://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm>



on our experience with evaluations. We also provide lessons learnt from the project experience and related recommendations (strategic and operational).

## 2.2. Evaluation methods and limitations

The evaluation is primarily based on a desk review of documents and data analysis, supplemented by consultations, as detailed below:

- **Document review:** Key documents reviewed (refer Annex 1) include the Memorandum of Understanding (MoU), progress reports, Board papers, formal communications between the two organisations and UNITAID internal progress review documents.
- **Consultations:** In-depth consultations were conducted with UNITAID and the Global Fund over a two-day visit in Geneva (with some additional consultations by phone). Annex 2 provides the list of consultees.
- **Quantitative analysis:** Key areas of analysis include a comparison of the original and actual expenditure in total, by treatment niche and by country; and review of the changes in the targets over time and comparison with the actual achievements as well as in relation to the total number of people on treatment at the country level.

Key limitations of our evaluation methods are as follows:

- Implementation delays coupled with organisational developments in both UNITAID and the Global Fund have implied that staff involved in the project have changed over time. There is limited institutional memory amongst both organisations on this grant (albeit with some key personnel still available and covered through our consultations). Additionally, there is some variation in the views of the individual consultees resulting from their engagement in the project at different times.
- Given the lack of visibility of the UNITAID grant within the Global Fund Round 6, we have not been able to consult with a wide range of stakeholders (e.g. beneficiary countries). We have only consulted with UNITAID and Global Fund staff, which may have resulted in a degree of bias and subjectivity in feedback. We have attempted to minimise the impact of this by objectively reviewing the available evidence and triangulating views across interviews, and against other documentary evidence, to the extent possible.
- Quantitative analysis has been constrained by inconsistencies and incompleteness in the M&E data presented in the progress reports; and in particular, specific information that would have enabled a richer public health and market impact analysis is not available.

These limitations are also discussed in the context of key issues in the implementation of the project in the following sections.

### 3. EVALUATION DIMENSION 1: DESIGN

We present our key review aspects on the design of the project (Section 3.1), followed by our analyses and assessments (Sections 3.2-3.4).

#### 3.1. Key review aspects

On the first evaluation dimension on design, our evaluation question is as follows:

**Q1: To what extent is the project aligned with and has contributed to UNITAID's goals and objectives?**

As part of our review, we consider: (i) the alignment of the project objectives with UNITAID's goals and objectives; (ii) the appropriateness of the detailed design of the project, as reflected in the MoU between the two organisations; and (iii) alignment of countries covered with UNITAID's country eligibility criteria.<sup>7</sup>

#### 3.2. Alignment of project objectives with UNITAID's goals and objectives

UNITAID's mission has remained constant over time and seeks to “contribute to scale-up access to treatment for HIV/AIDS, malaria and TB for people in developing countries by leveraging price reductions of quality drugs and diagnostics, which are currently unaffordable for most developing countries and to accelerate the pace at which they are made available”.<sup>8</sup> In line with this mandate, the objectives of the UNITAID contribution to Global Fund Round 6 sought to: (i) increase the number of patients accessing and receiving treatment; and (ii) support price reductions of high-quality drugs in the noted treatment niches.<sup>9</sup> As such therefore, the project objectives were closely aligned with UNITAID's overall objectives.

However, the overall structure and design of the project has not supported the achievement of the intended objectives. In particular, while the ‘access’ objective (i.e. increasing the number of patients accessing and receiving treatment) has been supported by providing funding to the Global Fund (as the key external funder for these treatment niches across developing countries), the ‘price reduction’ objective was not realistically attainable as:

- The funding was a *contribution* to the Global Fund Round 6 grants and there was no specific or clearly defined strategy on how market impact would be delivered (e.g. through a focus on specific commodities or direct engagement with the procurer). While it was proposed to use the mechanisms of pooled procurement and reference prices,

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<sup>7</sup> In our Inception Report, we had proposed to review the project's alignment with UNITAID's guiding principles (as reflected in its Constitution and recent strategies). These are reviewed in Section 5 – specifically on additionality and sustainability. We had also planned to review whether the project has fostered any innovation, as a key objective of UNITAID's business model. However, given the project was implemented through Global Fund's standard approaches and processes, there were no additional innovations. There were also no examples of innovation in the financial flows, information on procurement of drugs and results monitoring and reporting (as envisaged during the discussion at the Global Fund 15<sup>th</sup> Board meeting in 2007 (Ref: UNITAID Progress Update of the Global Fund Fifteenth Board Meeting (GF/B15/6) Attachment 2).

<sup>8</sup> <http://www.unitaid.eu/en/who/mission-and-strategy>

<sup>9</sup> Further, we understand that an additional objective of the project was also to encourage country demand for second-line and paediatric treatments, given limited country demand at that time.

these were not thought out in detail as to how they would be implemented (discussed further in Section 3.3).

- The project funding was spread too thinly across many drugs for three treatment niches and many countries – as per the MoU, US\$52.5m was to be provided for three treatment niches, 43 grants in 38 countries, and over 232 drugs. This implies that from a market perspective, the impact of individual and limited amounts of procurement would be diluted.

This is in comparison with some of UNITAID’s other projects which have been much more targeted and with a clear market strategy e.g. the Accelerating Scale-up of Long-Lasting Insecticide treated nets (LLINs) project with UNICEF focussed on the distribution of 20m LLINs in nine countries over a one year period; the ACT scale-up initiative with the Global Fund aimed to increase access and affordability of ACTs for 11 ongoing grants in eight countries; and funding to the Clinton Health Access Initiative (CHAI) for second-line ARVs aimed to use a series of interventions including pooled procurement and price negotiations to increase the number of suppliers and bring drugs prices down.<sup>10</sup> In addition, the project was not designed to deliver market impact that would contribute to improved access – as is the approach and mandate of UNITAID.

Our discussions with both UNITAID and the Global Fund highlight this misalignment or inconsistency of the project structure/ design with the planned objectives. UNITAID views this as a ‘legacy’ project, that was set up in the early days of its establishment, when it was looking to develop a strategic partnership with the Global Fund as a key player in the sector. In particular, the UNITAID Board was keen to ensure that UNITAID would not be perceived as a competitor or duplicate the work of the Global Fund. Thus, the motivations surrounding the development of the project were to lay the foundation for a long term partnership between the two organisations given their common objectives and areas of work.

From the Global Fund’s perspective as well, the project was a strategic investment to support future partnerships between the two organisations. This is evident from some of its Board documents, which highlight the importance of the project in the context of a broader potential collaboration with UNITAID. For example, at its 14<sup>th</sup> Board meeting, when UNITAID’s funding was accepted by the Global Fund, the Global Fund Board also requested that the two organisations work together to develop a strategic framework or “roadmap” for future collaboration.<sup>11</sup>

Thus, while the intended objectives of the project were aligned with UNITAID’s goals and objectives, these were not directly supported by the structure and design of the project – specifically in terms of market impact. The project was however an important basis for collaboration between the two organisations.

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<sup>10</sup> We have not evaluated these projects for alignment of their objectives with that of UNITAID or relevance of project activities – however cite these examples only to show the greater focus and use of specific market strategies in comparison to the Global Fund Round 6 grant.

<sup>11</sup> Global Fund (2007), “UNITAID Progress Update GF/B15/6 – Attachment 2”

### 3.3. Review of project design as per the MoU

As noted, the basic design of the project had some key limitations in relation to the project objectives. In addition, the structure of MoU, that established the detailed design of the project, had a number of weaknesses as described below.

#### *Inadequate design of the market mechanisms*

The MoU proposed the use of pooled procurement and reference prices to support price reductions in the treatment niches. However, the two mechanisms were not sufficiently structured/ detailed, which also implied that they were not implemented. In particular:

- There was no description of how the two mechanisms would be implemented in the MoU e.g. what would be the key activities to be undertaken, how would pooled procurement be facilitated, which reference prices were to be used and how. It is not clear if the expectation was that the Global Fund would set up a pooled procurement mechanism for this project – which would be unrealistic given the resource intensity and long-term nature of such a commitment.
- There was limited clarity on the roles and responsibilities of each organisation with respect to these mechanisms – while it was noted that UNITAID would provide strategic advice and the Global Fund would facilitate or implement these mechanisms, there was not sufficient clarity on how the two organisations would work together.
- No accountability measures were included in the design of the two market-based mechanisms to ensure their adoption and implementation.

From a design perspective, the two market-based approaches were poorly structured and lacked the appropriate level of detail to ensure they would bring about price reductions and improved affordability.<sup>12</sup>

#### *Mismatch between UNITAID's intrinsically 'earmarked' funding and the Global Fund's approach to reporting*

UNITAID's contribution was in effect a 'earmarked' contribution to the Global Fund Round 6, to be used specifically for the purchase of treatment drugs. The Global Fund however does not in general accept earmarked contributions, with funding from its donors being pooled and distributed to countries based on their approved grants. While the MoU recognises this funding approach and the difficulty in attributing funding and results to UNITAID (Clause 5.10.3), there was insufficient clarity (and expectations throughout the course of the project) on the reporting of results. In particular:

- There were no specific reporting provisions that allowed for a disaggregation of UNITAID's contribution from other Global Fund monies, implying that it was impossible to isolate the results that could be attributed to UNITAID.

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<sup>12</sup> In practice, there were also differences in expectations between the two organisations on how these mechanisms would be implemented – partly driven by changes in staff working on the project, as discussed in Section 4.

- There were no provisions and clarity on how the financial, programmatic and procurement reporting would be managed in light of the inability to disaggregate UNITAID's contribution from other Global Fund monies.
- More generally, the MoU did not include a log-frame against which to assess progress and achievements.<sup>13</sup>

Thus the design of the project was not aligned with the proposed M&E arrangements, resulting in considerable transaction costs during the course of the project. The M&E information provided by the Global Fund was not particularly useful for UNITAID's purposes. This is discussed further in Section 5.3

#### *Lack of detailed guidance on other relevant issues for implementation*

The MoU provided only high-level guidance on the implementation aspects relevant for the project. In particular, the MoU:

- did not specify clear roles and responsibilities for each partner, including specific provisions for non-performance;
- only provided an indicative list of the drugs that were to be procured under the project (Exhibit 2 of the MoU), which was not detailed enough or complete for the purposes of the project; and
- did not include any provisions for managing extensions or any other issues during implementation.

In summary, all these factors combined suggest that the MoU lacked the operational provisions to ensure effective implementation and reporting. These issues are also discussed in Sections 4 and 5, which highlight how the weaknesses in project design impacted implementation and results.

### **3.4. Country focus**

As per UNITAID's Constitution<sup>14</sup>, its funding to beneficiary countries must be consistent with its country eligibility criteria, which requires at least 85% of funding to be spent on lower-income countries, (LICs) with a maximum of 10% on lower middle income countries (LMICs) and 5% on upper middle income countries (UMICs). This is also reflected in the MoU for the project (Clause 4.3).

We have reviewed whether the country allocations under the project were in line with UNITAID's eligibility criteria, both in terms of the initial allocation (i.e. as per the MoU) and against actual funds spent at the end of the project (using UNITAID's reconciliation statement

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<sup>13</sup> It is important to note that at the time of MoU signing, UNITAID did not have an M&E team.

<sup>14</sup> UNITAID Constitution, Endorsed by the UNITAID Executive Board on May 9, 2007

of final expenditure<sup>15</sup>). The analysis is presented in Table 3.1, with the detailed country level analysis in Annex 3. The analysis indicates that:

- **At the time of MoU signing:** 87.4% of UNITAID’s total contribution was allocated to LICs, with the remaining 12.6% of funds for LMICs (no UMICs were funded). Thus the initial allocation was in line with UNITAID’s eligibility criteria.
- **Based on the final expended amounts:** 79.7% of funds were spent on LICs and 20.3% was spent in LMICs. The actual spending on LICs is below the 85% required by UNITAID. This is mainly due to the fact that the Mozambique grant was cancelled and that other grants were not fully expended.

*Table 3.1: Analysis of country allocation*

Allocations	LICs	LMICs
Allocation as per MoU (planned)	87.4% (45.9m)	12.6% (6.5m)
Allocation based on final expenditure (actual as per UNITAID reconciliation statement)	79.7% (21.5m)	20.3% (5.5m)

*Source: CEPA’s calculations based on the MoU and 2013 UNITAID reconciliation statement of final expenditure*

Thus, different from planned, the country focus under UNITAID’s funding to Global Fund Round 6 was not in line with its eligibility criteria – with a slightly higher share of funding being spent on LMICs.

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<sup>15</sup> The final expended amount was US\$26.9m according to the UNITAID reconciliation statement from July 2013, which was used as the basis for actual funds spent.

## 4. EVALUATION DIMENSION 2: IMPLEMENTATION

We present the key areas of focus for our review on the implementation of the project in Section 4.1 followed by our analyses and assessments in Sections 4.2 to 4.5.

### 4.1. Key review aspects

On the second evaluation dimension on implementation, our evaluation questions are as follows:

**Q2: Have the planned project activities been completed effectively, also on time and within budget?**

We focus here on: (i) funding of country grants by the Global Fund including grant selection, management and extensions; (ii) implementation of the procurement model in terms of the use of the reference price mechanism and pooled procurement; (iii) timeliness; and (iv) budgeting and financial management (Sections 4.2-4.4).

**Q3: How did the project perform in terms of overall management and what were the key strengths and weaknesses?**

We review project management in terms of the roles and responsibilities of the partners, approaches to collaborative working and key management issues relevant for the project such as the approval process for any changes (Section 4.5).

### 4.2. Grant selection, management and extensions

Our analysis of the funding of country grants by the Global Fund includes a review of the: (i) selection process for grants that would receive UNITAID funding; (ii) the experience of grant management under the project; and (iii) the process for managing project extension and completion.

#### 4.2.1. Selection process for UNITAID funding

As per the MoU, the Global Fund had the responsibility of determining which country proposals would receive funding under the project. The Global Fund reviewed the proposals submitted for Round 6 support in accordance with its standard procedures (i.e. independent review by the Technical Review Panel (TRP) and final approval by the Global Fund Board based on the recommendations of the TRP).

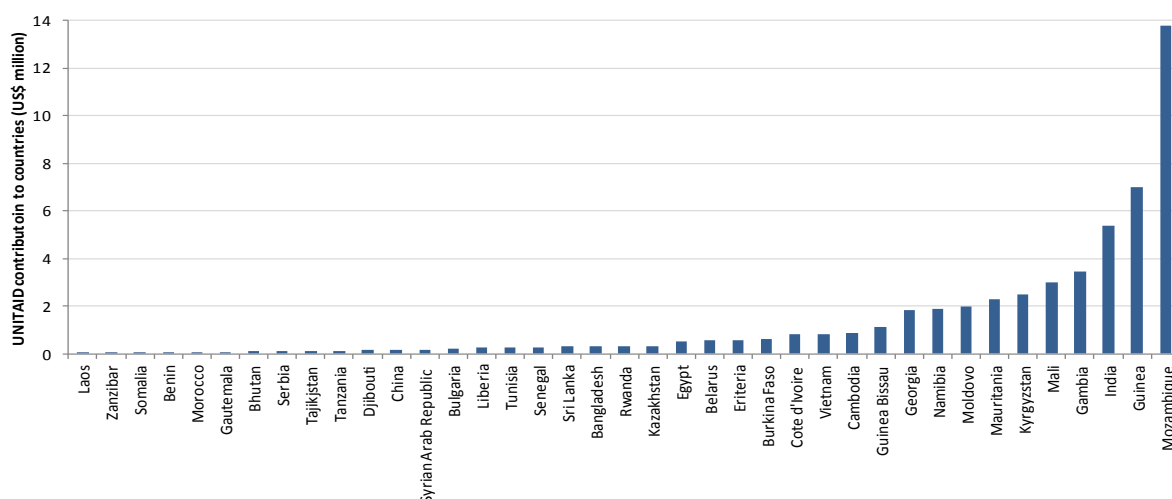
Given that Round 6 had already been launched at the time of finalising the MoU, we understand from discussions with the Global Fund that some of the grants were re-programmed to incorporate the UNITAID funding. The Global Fund determined which of the approved Round 6 proposals had requested support under the three treatment niches identified for the project; and its Fund Portfolio Managers (FPMs) further screened these to determine the allocation of UNITAID funding based on: (i) income level, consistent with UNITAID's country eligibility criteria (as discussed in Section 3.3); and (ii) country capacity for scale-up of targets. We do not have any further details on any additional criteria or processes for selecting the grants for

UNITAID funding, given the unavailability of relevant personnel who were involved in grant selection at the Global Fund.

Figure 4.1 shows the allocation of the UNITAID funding to countries. Key points to note are:

- The allocation of funding to countries varied substantially, ranging from US\$12k for Laos to US\$13.8m for Mozambique. There is also a wide variation in terms of the percentage of the total Round 6 approval accounted for by the UNITAID grant (not reflected in the figure) – e.g. the UNITAID contribution accounted for 0.2% of the total Somalia Round 6 grant and 90% of the total Mali Round 6 grant.
- More than a quarter of the overall UNITAID project was allocated to Mozambique (US\$13.8m), to be disbursed subject to fulfilment of certain conditions.<sup>16</sup> As these funds were not utilised in the end, in our view, such a sizable allocation to a single country represents inefficient/ poor programming.

Figure 4.1: UNITAID grant allocation to countries



Source: The MoU

#### 4.2.2. Global Fund grant management

The UNITAID contribution was managed by the Global Fund in line with its standard policies and procedures; and no new mechanisms were set-up for the management of the UNITAID funds. While a review of Global Fund's grant management processes is beyond the scope of this work, we note the following:

- As per the November 2010 report from the Global Fund<sup>17</sup>, 28 grants (or 65% of the 43 grants) had not achieved their objectives and it was suggested that five grants (or 11%) should be closed-out as it was not expected that these grants would achieve their targets.

<sup>16</sup> Due to a likely risk of duplication, a provision for withholding remittance of funds for Mozambique for paediatric and 2nd line ARVs was incorporated in the MoU. Eventually, the Global Fund decided not to avail of the funding for Mozambique, since it only requested for US\$851 for the procurement of ARVs under Round 6 (potentially because the country might have procured resources from other sources).

<sup>17</sup> Global Fund (2010), "Going Forward – UNITAID Support for the Global Fund Round 6, November 2010"



This performance suggests that it would be helpful to understand what were the challenges faced by the poor/ non performing grants and what approaches were followed by the Global Fund to support countries in achieving their results (both in terms of ex-ante risk management and ex-post effectiveness/ results management). From our review of the successive progress reports, it is not clear how emerging country issues (e.g. delayed arrival of ACTs in Guinea, lower malaria prevalence in Djibouti, transfer of activities to another Principal Recipient (PR) in Cote d'Ivoire<sup>18</sup>) were managed by the Global Fund. The UNITAID Secretariat also notes the lack of sufficient information on in-country actions in their review of the Global Fund progress reports and has consistently requested for additional information. Our understanding is that the Global Fund collects comprehensive information on grant implementation and issues and it is not clear why this information could not be shared with UNITAID, especially given the request.

- Following discussions with the Global Fund, we note that its grant management processes as a whole have improved over time based on lessons learnt from experience. For example, following the recognition of fiduciary risks, the Global Fund introduced specific financial and risk management policies through its Office of the Inspector General (OIG). Whereas previously, any issue noted by the OIG resulted in immediate suspension of the grant, the Global Fund is now looking to consider ways to re-programme the grant in order to avoid termination of key life-saving activities (e.g. by transferring the grant to another PR).<sup>19</sup>

The lack of information on grant management and risk mitigation measures to address emerging issues were noted as challenges by UNITAID during the course of the project.<sup>20</sup> We agree that additional information on these issues might have been useful to include in the progress reporting (while balancing any excessive transaction costs on the Global Fund as a result of this) so as to enable both organisations to consider if any mid-term course correction might be useful (e.g. earlier re-programming of some country-level grants such as Mozambique, given it was not utilised).<sup>21</sup>

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<sup>18</sup> Global Fund (2010), “3<sup>rd</sup> Annual Progress Report”

<sup>19</sup> The Global Fund is currently developing a new funding model to provide implementers with more flexible timing, better alignment with national strategies and greater predictability on the level of funding; and entails more active engagement with implementers and partners throughout grant application and implementation. (<http://www.theglobalfund.org/en/activities/fundingmodel/>). We were informed that the new model foresees that the Fund adopting a more responsive and pro-active grant management approach, with greater oversight based on the implementers' level of risk, and is also expected to improve the quality of reporting going forward.

<sup>20</sup> In our consultations with the Global Fund we have tried to understand what were the main issues faced by countries and what worked well and not so well in terms of Global Fund's grant management processes – however, we were unable to obtain sufficient detail given the changes in staff involved in the project.

<sup>21</sup> Additionally, a mid-term evaluation was not carried out for the project. This prevented both organisations to engage in discussion on how they could have implemented mid-term course-corrections that could have addressed some of the implementation-related issues.

### 4.2.3. Process for managing the project extension and completion

The MoU had anticipated completion of the project by June 2010 and also included a provision on the approach to estimation of any unexpended funds.<sup>22</sup> Given this, UNITAID initiated early discussions with the Global Fund in December 2009 to understand their intent of drawing upon this provision. Following this, we understand that:

- The Global Fund submitted a formal request for extension in July 2010<sup>23</sup>, after the lapse of the completion date for the project (June 2010), and requested a no-cost extension for 13 grants which had not yet fully achieved their targets.<sup>24</sup> However, the letter did not provide a justification for the request nor a quantification of the unexpended UNITAID amount.
- Following UNITAID's request to provide a justification for a no-cost extension<sup>25</sup>, the Global Fund submitted a report in November 2010, that made specific recommendations for each of the grants included under the project. The report indicated that 15 grants achieved 100% of targets, whilst 28 grants achieved between 0% and 88% of targets.<sup>26</sup>

In our review of these communications and report on project extension, we note that: (i) it would have been useful to discuss and agree any extension before the pre-agreed completion date; and (ii) the discrepancy between the number of grants reported as having achieved their targets in the July and November 2010 letter/ report highlight the issues in reporting against this grant (also discussed further in Section 5.3 on results).

The Global Fund also suggested that the MoU should be revised to allow part of the unexpended funds to be reinvested in related projects, with approval from UNITAID. For example, the Global Fund proposed to use the unexpended funds from the Namibia grant to support malaria pre-elimination efforts given that the requirements for ACTs had been lower than expected. However, we understand that UNITAID was keen for the unexpended amount to be used exclusively for the project's objectives in line with the MoU provisions (i.e. for the purchase of treatment drugs), and thus the unexpended funds were not re-programmed as per Global Fund's suggestion. In our view, some flexibility to re-programme the unexpended funds

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<sup>22</sup> Clauses 5.3 and 14.1. Note that these clauses are referenced in some communication between UNITAID and Global Fund but not include in the copy of the MoU provided to CEPA as a reference for this evaluation.

<sup>23</sup> Letter from the Global Fund to UNITAID, dated July 13<sup>th</sup> 2010.

<sup>24</sup> The remaining 29 grants were considered to have achieved their targets (and the Mozambique grant was not used).

<sup>25</sup> Letter from UNITAID to Global Fund, dated 16<sup>th</sup> August 2010.

<sup>26</sup> Global Fund (2010), "Going Forward – UNITAID Support for Global Fund Round 6". The recommendations for the extensions made in the report were based on: (i) results achieved thus far; (ii) performance of the treatment programmes; and (iii) recommendations of individual FPMs on future performance and plausibility of achieving the targets. Based on these criteria the Global Fund recommended: (i) 15 grants (14 countries) had fully achieved their targets, and fully utilised the funds, and the project should be considered as complete; (ii) in 13 grants (12 countries) which had achieved 60% or more of the targets, UNITAID project support should be extended by one year for the countries to reach 100% of their target; (iii) in 7 countries (7 grants) which achieved 20-60% of the target, five grants should be allowed one year to achieve results, but the project should be closed in two countries (Mali due to OIG investigation and Cote d'Ivoire due to interruption of the grant and lack of treatment component in Phase II); (iv) 8 countries achieved less than 20% of their target, out of which the Global Fund recommended close out of three grants (Mauritania, Djibouti and Sri Lanka), while extending project support for the remaining five grants.

might have allowed for the more effective use of the project funds – e.g. funding for additional treatment targets in the existing countries or funding for additional countries. A clearer process of project extension could have also resulted in the funds being reprogrammed and utilised to support well-performing grants.

Following the project extension, the project came to an end in December 2012 and the Global Fund provided a final report in May 2013. However, there have been diverging views on the final unexpended amount under the project, preventing the final closure of the project. This is discussed in more detail in Section 4.4.2 below.

### **4.3. Procurement model**

As per the MoU, UNITAID and the Global Fund agreed to employ a procurement strategy that would positively impact market dynamics through two approaches, namely: (i) pooled procurement; and (ii) reference prices. As noted in Section 3, the two approaches were not adequately designed for the purposes of the project and there was insufficient clarity on how these would be implemented. In this section, we describe whether and how the two market based approaches were implemented under the project.

#### *Pooled procurement*

By design, there was lack of clarity and details in relation to the potential structuring of a pooled procurement mechanism under this project. This resulted in the Global Fund not actively pursuing a pooled procurement strategy. Feedback from both UNITAID and Global Fund also notes that there was limited dialogue and discussions between the two organisations on this (as was planned for in the MoU). The Final Financial and Programmatic Report (May 2013) submitted by the Global Fund also noted that “pooled procurement was encouraged but not organised on a global level”.<sup>27</sup>

PRs largely used national-level procurement mechanisms under the project – and the limited pooled procurement that did take place under the project was mostly ad hoc and supported by mechanisms that were established independently of this project:

- MDR-TB drugs were procured through the Global Drug Facility (GDF) as per the MoU (although this pooled procurement mechanism cannot be attributed to the project).
- Some grants benefitted from the Global Fund Voluntary Pooled Procurement (VPP) mechanism. However, given that VPP became operational in 2009, only a few countries availed of this mechanism (five countries and seven grants).<sup>28</sup> Further, we understand from the Global Fund, that the VPP was used mostly as a risk mitigation measure (since it was aimed at countries with financial/ fiduciary issues where Global Fund was unable to transfer funds directly), rather than aiming to actively impact market dynamics. Nonetheless, consultations with the Global Fund suggest that through the VPP, seven grants were able to benefit from: lowest prices available (despite small volume of orders);

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<sup>27</sup> Global Fund (2013), “UNITAID Support for Global Fund Round 6: Final Financial and Programmatic Report”

<sup>28</sup> These were ACTs: Bangladesh, Djibouti, and Guinea Bissau; ARVs: Lao and Guinea; MDR-TB: Laos and Djibouti.

delivery of treatments despite country-level disruptions; and faster procurement than national procurement timelines, which average 9-12 months.

### *Reference price mechanism*

As agreed in the MoU, the Global Fund and UNITAID were jointly responsible for facilitating the use of reference pricing to support price reduction of drugs in the specified treatment niches – with the role of UNITAID being to provide strategic advice and that of the Global Fund to facilitate/ implement the mechanism (Clause 4).

However reference prices were not considered throughout the course of the project. Consultations suggest that there were diverging expectations on who would provide the reference prices – UNITAID expected the Global Fund to have access to international reference prices (being the largest global funder for drug procurement) or obtain these from GDF and UNICEF for MDR-TB drugs and ACTs respectively<sup>29</sup>; while the Global Fund expected these to be supplied by UNITAID (the annual progress reports state that “no UNITAID reference prices have been supplied so it has not been possible to compare reference prices”). The long timeframe for the implementation of the project and consequent changes in staff working on the project at both the Global Fund and UNITAID contributed to this confusion.

Thus, ultimately both market mechanisms were not actively employed in the project (notwithstanding their inadequate design). Additional dialogue and agreement between UNITAID and the Global Fund may have led to their uptake to the extent feasible – e.g. while not contributing to reduced prices per se, a consideration of reference prices in the project could have allowed for an analysis of whether country procurement of the treatment drugs was efficient or not.

## **4.4. Timelines and finances**

### **4.4.1. Timelines**

The UNITAID contribution was designed to support Phase I of Round 6, which covered the first two years of Round 6 (approximately 2008 to 2010). The UNITAID project targets were Phase I targets and were determined by the Global Fund based on the original country proposals. Therefore, the overall timeline for the project was aligned with the Global Fund project cycle.

Figure 4.2 presents the project timeline and key events. In general, the project has performed poorly with respect to timeliness in that:

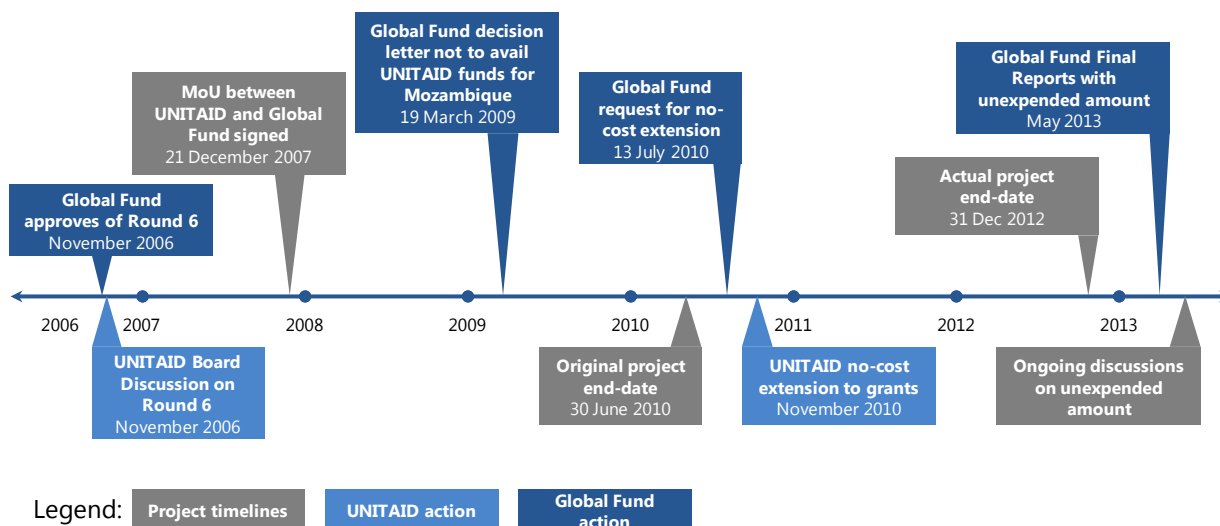
- While the UNITAID contribution was accepted by the Global Fund at its Fourteenth Board meeting in November 2006, the MoU between the two organisations was signed a year later in December 2007, by which time Round 6 had already commenced.
- There was a delay of almost 2.5 years in completing the project (i.e. almost double of the original project timeframe). Further, there have been issues in closing the project given

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<sup>29</sup> UNITAID had suggested that GDF and UNICEF prices be used as baseline prices for TB and malaria. Source: UNITAID review of 2nd Annual Procurement and M&E reports.

inconsistencies in the final M&E information provided by the Global Fund and differing views on how to calculate the unexpended amount under the project (with discussions currently ongoing, however expected to be concluded in September). This is discussed in more detail in Section 4.4.2 below.

Figure 4.2: Main events in project timeline



#### 4.4.2. Budget and financial management

UNITAID committed US\$52.5m for the project to be disbursed in two tranches as follows: (i) a first disbursement of US\$38.7m to be paid to the Global Fund within 10 days of MoU signature; and (ii) a second disbursement of US\$13.8m to be paid to Global Fund for the Mozambique grant on fulfilment of certain conditions. We understand that the first disbursement was paid in a timely manner and the second disbursement was not called upon as Mozambique did not require the funds.

In our assessment, key issues in budget and financial management are as follows:

##### *Large allocation to a single country reduced flexibility*

As noted, in our view, allocating almost a quarter of the overall project funding to a single country (Mozambique, US\$13.8m) represents inefficient/ poor programming (although we recognise the large need for HIV drugs in the country). This amount was never disbursed to the Global Fund, given that re-programming the grant would have entailed a lengthy and time consuming process. In our view, more efforts should have been made to utilise the funds to achieve better results in other countries.

##### *Single tranche disbursement did not promote efficiency*

The Global Fund received the full disbursement of US\$38.7m from UNITAID in a single tranche. While on the one hand, disbursing a single tranche provided the Global Fund with the flexibility and availability of funds to disburse to countries in line with their Procurement and Supply Management (PSM) plans, in our view, given the several grant management issues, a more phased approach to disbursement could have been adopted to ensure efficiency from a

financial management perspective. We understand that phased disbursements are now a standard practice in UNITAID’s projects and are based on: (i) project performance; (ii) cash needs; and (iii) adequacy/ completeness of financial reporting.

*There is a considerable difference between the planned and actual final spend on the project, which represents an inefficient use of resources*

The final amount spent under the project was US\$26.9m or 51% of the planned total (Table 4.1). In our view, the low expenditure rate represents an inefficient use of resources, given that the funds were committed but not utilised or re-programmed over the five year project period.

*Table 4.1: Comparison of planned and actual spend under the project*

Treatment Niche	Planned spend (US\$m)	Planned without Mozambique (US\$m)	Actual spend (US\$m)	Spend as % of planned	Spend as % of planned without Mozambique
Total	52.5	38.7	26.9	51%	70%

*Source: CEPA calculations based on the MoU and UNITAID reconciliation statement*

*Lack of clarity on the calculation of the project unexpended amount has resulted in considerable additional transaction costs*

The MoU provided guidance on calculating the unexpended amount under the project.<sup>30</sup> In 2010, Global Fund presented a summary of the unexpended amount in its report to UNITAID, however differences in opinion on the interpretation of the MoU as well as use of diverging data (due to inconsistencies in reporting<sup>31</sup>) resulted in a disagreement on the unexpended amount and it was planned instead to extend the project.

Following the extension, in 2012, UNITAID and the Global Fund agreed to use a ‘pro-rated methodology’ to calculate the unexpended amount, wherein expended funds were to be based on the extent of targets reached (i.e. if 35% of the targets were reached then it was assumed that 35% of the funded were expended).<sup>32</sup> However, again, difference in interpreting the agreement as well as data used for the calculation resulted in another disagreement on the expended amount – the Global Fund proposed the unexpended figure to be US\$10.97m, while UNITAID’s reconciliation concluded on US\$11.8m.<sup>33</sup> We understand that the two organisations are now close to agreeing on a final unexpended balance for the project.

<sup>30</sup> Section 5.3 of the MoU outlines the formula to be used to compute the unexpended balance. This formula was used by the Global Fund to compute the unexpended amount presented in the final programmatic and financial report submitted to UNITAID in September 2010, prior to the extension to Phase II.

<sup>31</sup> Because of changes in treatment targets that were not consistently reported to UNITAID, the two organisations are working on a different basis of results achieved.

<sup>32</sup> It is important to note that this methodology is not ideal because it is based solely on actual results achieved, thereby ‘penalising’ the Global Fund in cases where countries might have procured the goods but not have been able to provide treatment to patients.

<sup>33</sup> We understand that the difference in the calculation of the unexpended amount is on account of the following: (i) differences in agreed targets as per the MoU and the Global Fund progress reports for some countries; (ii) differences in achievement of targets between different files sent by the Global Fund; and (iii) Global Fund’s

Thus lack of clear guidance in the MoU and M&E data discrepancies during the project have resulted in considerable transaction costs for both organisations in calculating the project finances. In addition, in February 2013, the UNITAID Board decided to allocate the unexpended amount under the project to the AMFm transition year<sup>34</sup> – however delays in reaching an agreement on the amount has resulted in delays in the transfer of funds to AMFm.

#### 4.5. Project management

Our review suggests a number of issues in project management as follows:

- **While the MoU defined a set of roles and responsibilities for the two parties these were not detailed enough and required more clarity.** Consultations suggest that there was lack of clarity on the roles of the two organisations with regard to some activities under the project (e.g. on provision of reference prices).
- **There were limited efforts for collaborative working under the project.** We understand that there was limited collaborative working between the two organisations towards achieving the project objectives. This was in part due to a lack of clarity on the respective roles and in part to the high project personnel turnover in the Global Fund and internal developments within UNITAID. Consultations suggest that UNITAID perceived itself as a ‘partner’ in the project, while Global Fund viewed UNITAID as a donor contributing resources to Round 6.
- **There was a lack of effective communication throughout the course of the project.** Communication has been a key issue for the project, with limited follow-up to address emerging issues and challenges (e.g. both organisations commented that letters exchanged remained unanswered for months). Further, the project structure at the Global Fund also led to delays in communication as the donor relations team rather than programme staff was the main point of contact.
- **Approval processes and information exchanges were not always followed as per the specifications in the MoU.** We understand that project level changes (such as changes in the funding allocation by treatment niche) were to be approved by UNITAID, however these were not done. Other changes, such as revisions to country targets<sup>35</sup> and changes to drugs and formulations from that set out in Exhibit 2 of the MoU were to be informed to UNITAID – but this was not consistently done resulting in considerable data discrepancies between the two organisations.

Thus in general, project management was far from optimal, resulting in considerable additional transaction costs for UNITAID in particular, but also the Global Fund.

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application of a 25% discount for buffer stock in some countries, which UNITAID did not apply in their calculation.

<sup>34</sup> UNITAID (2013), “Second Letter of Amendment to the MoU between UNITAID and the Global Fund to Provide Additional Funding to the AMFm Transition Year 2013”.

<sup>35</sup> We were informed of different provisions in the MoU on this (e.g. targets could be increased without seeking UNITAID’s agreement, but could only be reduced with UNITAID’s approval) but have not been able to confirm which is correct.

## 5. EVALUATION DIMENSION 3: RESULTS

We present the key aspects of our review on the results of the project (Section 5.1), followed by our analyses and assessments (Sections 5.2-5.4).

### 5.1. Key review aspects

We review the results of the project in terms of: (i) achievement of public health and market impact; (ii) efficacy of the M&E systems; and (iii) sustainability of UNITAID funding. Our evaluation questions are as follows:

**Q4: What was the market and public health impact of the project, particularly against the two objectives?**

We review the project achievements as reported by the Global Fund, including comparing with the number of people treated in the countries across the treatment niches, as a measure of the contribution of UNITAID. We also review the additionality of the project. (Section 5.2)

**Q5: To what extent have M&E systems supported the achievement and attribution of results?**

We assess the efficacy of the M&E system and approaches for the project and comment on key issues. (Section 5.3)

**Q6: To what degree are project benefits likely to continue after UNITAID funding is withdrawn?**

We review the sustainability of UNITAID funding – both in terms of the financial sustainability of funding to the Global Fund as well as programmatic sustainability (i.e. whether any approaches/ systems developed under the project can be sustained). However, given the experience with the project (as outlined in the previous sections), our review of project sustainability is quite limited. (Section 5.4)

### 5.2. Project impact

In assessing project impact, we consider: (i) the progress reported by the Global Fund in its annual progress reports, particularly in terms of planned targets versus actual final achievements; (ii) a broader assessment of the public health impact achieved under the project by contextualising the number of people treated under the project (as reported by the Global Fund) with the total number of people treated in the countries (using data from WHO, UNAIDS and the World Malaria Report); and (iii) whether the UNITAID funding has been additional. Our review is constrained by the availability of M&E information on the project (Section 5.3 below discusses a number of key M&E issues relating to incompleteness/ limited utility and inconsistencies in the Global Fund progress reporting over the years).

Our assessment of project impact considers the *contribution* of UNITAID funding (and is not aimed at *attribution*), given that it is not possible to isolate the UNITAID funds and impact from that of other donors contributing to Global Fund Round 6 (and other sources of funding for the country).



### 5.2.1. Summary of project results

We have reviewed the overall progress reported by the Global Fund for the project and summarise the key points below. Annex 4 provides additional analysis on the achievements against the targets.

*There is a considerable difference between the planned and actual final spend on the project by treatment niche suggesting lower than planned ‘demand creation’ for paediatric HIV drugs and 2<sup>nd</sup> line ARVs.*

As noted in Section 4.4.2, actual spend under the project was 51% of the planned spend (70% excluding Mozambique). The reduced actual expenditure has implied a different allocation by treatment niche from what was planned in the MoU (Table 5.1), with a much lower percentage allocation for paediatric HIV drugs and 2<sup>nd</sup> line ARVs and higher percentage allocation for MDR-TB as compared to the original allocation. This was primarily due to the Mozambique grant not being availed of, resulting in lower than envisioned spend on paediatric HIV drugs and 2<sup>nd</sup> line ARVs.

Given that one of the intended objectives of the project was to encourage increased country demand particularly for paediatric HIV drugs and 2<sup>nd</sup> line ARVs, this reduced final spend implies that this ‘demand creation’ objective was only partially achieved.

*Table 5.1: Comparison of planned and actual spend under the project by treatment niche*

Treatment Niche	Planned spend (US\$ m)	% per treatment niche	Planned spend excl. Moz (US\$ m)	% per treatment niche	Actual spend (US\$m)	% per treatment niche
Paediatric HIV	12	23%	5.5	14%	5.3	20%
2nd line ARV	8.7	17%	1.4	4%	1.3	5%
ACT	21.5	41%	21.5	56%	10.9	40%
MDR-TB	10.3	20%	10.3	27%	9.3	35%
<b>Total</b>	<b>52.5</b>	<b>100%</b>	<b>38.7</b>	<b>100%</b>	<b>26.9</b>	<b>100%</b>

*Source: CEPA calculations based on the MoU and UNITAID reconciliation statement*

*Commensurate with the lower than planned spend, project achievements in terms of number of people treated (in total) has also fallen considerably short of the intended targets*

The MoU had set a target of reaching 11.5m people with the treatment drugs and this was revised to 6.8m people after the Global Fund decided not to avail of financial support for Mozambique and a few other country targets were revised during the extension process in November 2010.<sup>36</sup> As noted in the Final Financial and Programmatic Report (May 2013), 4.6m

<sup>36</sup> The revised 6.8m target is based on: (i) removal of Mozambique targets – while the funds for Mozambique were substantial, the number of people to be reached was small (300,000); (ii) downwards revision for the targets for China; (iii) upward revisions for the targets for: Cambodia, Guinea, Lao PDR, Senegal and Serbia; and (iv) close-out of the malaria grants for Cote d’Ivoire, Djibouti, Mali, Mauritania, and the TB grant for Sri Lanka.

people were treated from 2007 to 2012 i.e. 40% of the original planned targets (or 41% if the planned contribution to Mozambique is excluded).<sup>37</sup>

Table 5.2 reports the final achievements by treatment niche, which shows that there is a considerable variation in the results achieved under the treatment niches – with MDR-TB surpassing the original target and ACTs achieving less than 50% of the original target. (Note that if one compares planned targets versus actual results excluding the allocation for Mozambique, the achievement is much higher for paediatric HIV and 2<sup>nd</sup> line ARVs).

*Table 5.2: Comparison of original and actual targets on number of people reached with treatment drugs, in total and by treatment niche*

Treatment Niche	Planned targets	Planned targets excl. Moz.	Actual results achieved	Results achieved as a % of planned	Results achieved as a % of planned (excl Moz)
Paediatric HIV	194,561	29,561	32,810	17%	111%
2nd line ARV	172,465	7,465	8,615	5%	115%
ACT	11,173,036	11,173,036	4,554,962	41%	41%
MDR-TB	3,298	3,298	4,153	126%	126%
<b>Total</b>	<b>11,543,360</b>	<b>11,213,360</b>	<b>4,600,540</b>	<b>40%</b>	<b>41%</b>

*Source: CEPA calculations based on Global Fund progress reports*

We note that for MDR-TB, paediatric HIV and 2<sup>nd</sup> line ARVs, the overall targets have been surpassed, although the actual spend was lower than planned. This is due to the fact that there was considerable divergence between the original targets and actual achievements for individual countries, with some countries achieving more than double their original targets<sup>38</sup> (e.g. Tajikistan) and others achieving less than 50% of targets (e.g. Guinea). Table 5.3 provides an overview of countries' achievements.

*Table 5.3: Target achievement of grants<sup>39</sup>*

Indicator	Achieved 100% or more of target <sup>40</sup>	Achieved 50-100% of target	Achieved less than 50% of target
Number of grants	28	7	7

<sup>37</sup> We understand from discussions with UNTAID that is a relatively small achievement compared to some of its other projects, which although not directly comparable due to differences in design, funding approaches and duration, have led to much higher numbers of people reached for treatment.

<sup>38</sup> Also to note that when a country surpassed its planned targets, the amount spent was considered to be 100% of the grant (as per the agreed methodology to calculate the expended amount under the project).

<sup>39</sup> This analysis does not include the Mozambique grant.

<sup>40</sup> We note that there is a considerable discrepancy in the number of grants reported to have achieved their targets. In the Final Financial and Programmatic Report (May 2013), the Global Fund states that 35 countries have achieved 100% or more of their targets. However, as per UNTAID reconciliation statement, 28 countries have reached more than 100% or more of their targets.

*Source: CEPA calculations based on UNITAID reconciliation statement*

*There is insufficient information to assess achievements in terms of market impact<sup>41</sup> (notwithstanding the fact that by design there was limited potential for market impact)*

As noted in the sections above, given the ‘umbrella’ nature of the grant (spread across many countries and many treatment drugs) and the lack of a clear market strategy, by design, the project did not realistically support its intended market impact objectives. In addition, during the course of implementation of the project, there has not been any active pursuance of the proposed market strategies of pooled procurement and use of reference prices as benchmarks, and hence there was limited scope for market impact through these mechanisms. Some market impact may have been achieved in general through the funding of treatment drugs, however it is not possible to study this in any detail given the lack of required M&E information (including the fact that no targets were set for market impact in the MoU). The Final Financial and Programmatic report submitted to UNITAID in May 2013 also states that “in the case of the second objective [i.e. market impact], the price dynamic is inconclusive between 2007 and 2010.”<sup>42</sup>

In the Inception Report, we had proposed to conduct a market impact analysis (subject to availability of data) to determine price reductions in the cost of drugs resulting from the project by comparing: (i) estimated and actual drug unit costs; and (ii) actual drug unit costs with international reference prices. However, the procurement annexes included as part of the annual progress reports do not provide sufficient information and also there are some inconsistencies across years between the reports (see Section 5.3 below). Hence we have been unable to review this information in any useful manner.<sup>43</sup>

### **5.2.2. Review of public health impact**

We have undertaken a more detailed review of the public health impact of the project by comparing the reported number of people reached as per the Global Fund progress reports with the total number of people treated (for HIV) and cases reported (for malaria and MDR-TB) in each country (using data from WHO, UNAIDS and the World Malaria Report). We have conducted the analysis for the period 2008-10 as this was the original Phase I timeline against

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<sup>41</sup> Although there is no agreed definition of market impact, as per the 2013-2016 Strategy, market shortcomings that UNITAID seeks to address through its market impact interventions are: (i) availability; (ii) affordability; (iii) quality; (iv) acceptability/ adaptability; and (v) delivery.

<sup>42</sup> The Final Financial and Programmatic Report (2013) notes that there was a significant increase in prices of TB drugs between 2008 and 2010; and the prices of paediatric and 2<sup>nd</sup> line ARVs decreased on an average 32.6% between 2008 and 2009, although there was a high variance of drug prices between low and middle income countries.

<sup>43</sup> Had the data been tracked and compiled, in our view, a market impact analysis could have comprised: an examination of the price variation over the course of the project (with the expectation that price will be lower at the end of the project); assessment to determine if high prices exist because of monopolistic competition along the value chain, collusive behaviour, corruption, compromised procurement practices etc; assessment to determine if companies are moving towards or away from niche markets; trends and projections by market size and purchaser, amongst others.

which the country targets had been proposed.<sup>44</sup> We have used the actual numbers of people treated and do not consider planned versus actual expenditures in this assessment.

In general, the analysis is likely to portray an overestimation of the UNITAID contribution as the total number of people treated/ cases reported considers public sector data only. Given that UNITAID funds are provided in addition to other resources in countries, the analysis should be interpreted with caution, taking into account that overall impact is not directly attributable to UNITAID.

In summary, 2.8m people were reported to have been treated with UNITAID's contribution to Global Fund Round 6 across the three treatment niches (note that this is for the period 2008-10 only), as compared to a total of 8.4m reported treatments/ cases at the country level i.e. UNITAID's contributed to 34% of the total. UNITAID's contribution supported treatment for more than 50% of the MDR-TB cases in Georgia, Bhutan, Rwanda and Syrian Arab Republic; more than 60% of uncomplicated malaria cases in Somalia, Eriteria and Cambodia; and more than 50% of ARV treatment for most countries covered under the project.

Key points by treatment niche are provided below, with more details in Annex 5.

#### *MDR-TB*

The country indicators reported in the Global Fund progress reports were not specific enough to discern the category of TB cases supported by the UNITAID funding (i.e. new or new and returning). For our analysis, we estimate UNITAID's contribution by comparing the actual number of MDR-TB patients treated by UNITAID to the new and retreated cases for the period 2008-10 inclusive using country data as reported by WHO.<sup>45</sup>

Figure 5.1 illustrates the estimated UNITAID contribution to the supported countries. Key points to note are the following:

- In the 17 countries to which UNITAID contributed resources for MDR-TB treatment, 23,054 new and retreated cases on treatment were reported between 2008 and 2010. UNITAID contributed treatment to 3,168 cases (equivalent to approximately 14% of the total new and retreated cases reported over the period).<sup>46</sup>
- UNITAID's contribution to number of new and retreated cases ranges from 4% in Kazakhstan to 77% in the Syrian Arab Republic.

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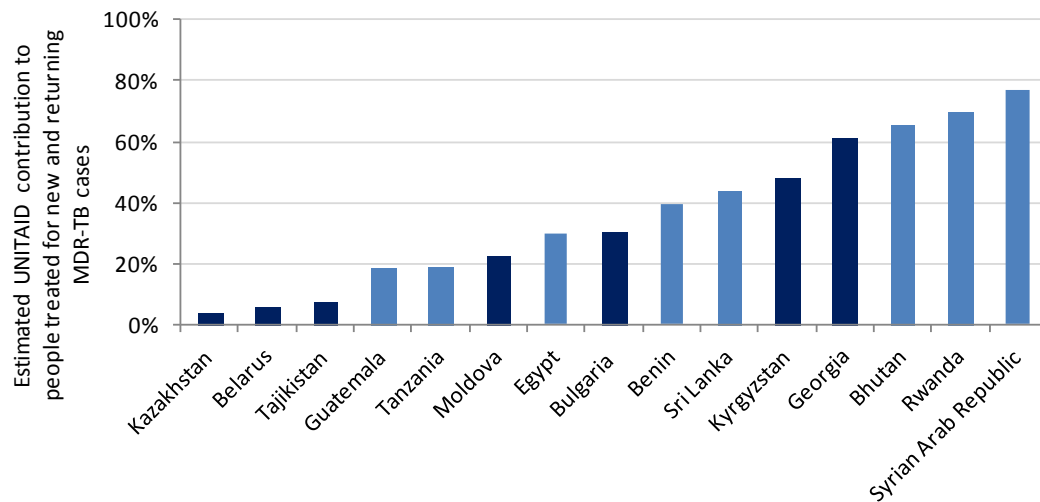
<sup>44</sup> In our view it is not useful to conduct the analysis for the overall project period (i.e. up to December 2012), given that the project had been designed to support countries during Phase I of Round 6 (approx the first two years of the grant).

<sup>45</sup> Source: Case notification data provided by country and territories (2011) available at <http://www.who.int/tb/country/data/download/en/index.html>

<sup>46</sup> Note that we have had to exclude Vietnam and India from the analysis as no data is provided for Vietnam on the WHO database; and no progress is reported for India in the Global Fund progress report.

- In some high MDR-TB burden countries<sup>47</sup> such as Georgia and Kyrgyzstan, UNITAID's contribution supported the treatment of more than 40% of all MDR-TB cases between 2008 and 2010.

Figure 5.1: UNITAID contribution to people treated for new and returning MDR-TB cases



Notes: Dark-blue columns are high-burden MDR-TB countries.

### Malaria

The total number of reported uncomplicated malaria cases were collated from WHO reports (World Malaria Report 2011) and totals calculated for 2008 – mid 2010 inclusive. The estimated UNITAID contribution was calculated using the total number of people treated with ACTs compared to the total estimated number of reported malaria cases.

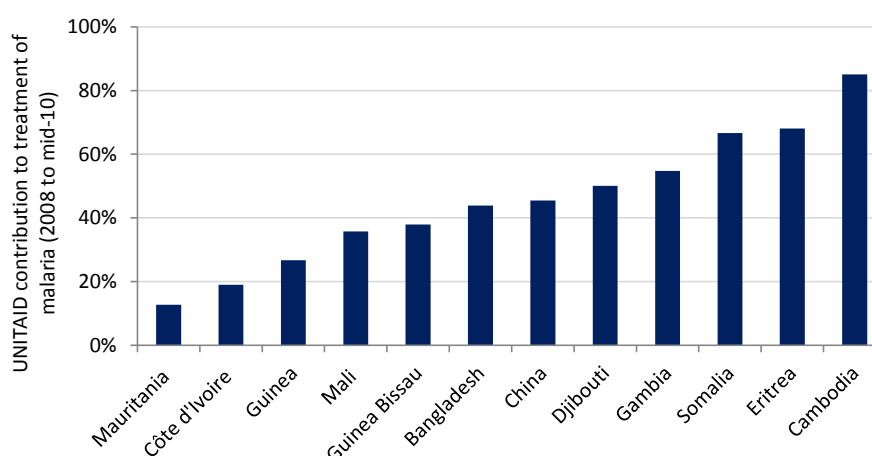
Figure 5.2 illustrates the estimated UNITAID contribution in the 13 countries that received support (taking into account that in three countries treatment was to be targeted only at children under-five as per the national level indicators reported by the Global Fund in its annual progress reports<sup>48</sup>). Key points to note are as follows:

- As of mid-2010, 8.4m uncomplicated cases of malaria were reported in the 13 countries, of which 2.8m people were treated under the Round 6 Phase I support, constituting 34% of the total reported number of uncomplicated malaria cases.
- At the country level, UNITAID's contribution to the number of uncomplicated malaria cases ranged from 13% in Mauritania to over 85% in Cambodia.

<sup>47</sup> Source: Table 2.3 from WHO (2012) Global TB Report, available at [http://www.who.int/tb/publications/global\\_report/gtbr12\\_main.pdf](http://www.who.int/tb/publications/global_report/gtbr12_main.pdf)

<sup>48</sup> The three countries are Gambia, Cote d'Ivoire and Mali. To account for an indicator that only targeted children under-five, the transmission intensity of malaria in each country was considered and proportion of cases in under-fives estimated. See Annex 5 for more details on the methodology.

Figure 5.2: UNITAID contribution to people treated for uncomplicated malaria cases<sup>49</sup>



### HIV/AIDS

UNITAID's contribution was assessed against the number of people on ARV treatment in 2010. The total number of people on ARV treatment as of 2010 was collated from UNAIDS (UNAIDS, 2010 and 2011). There are two major caveats to this analysis that might result in an underestimation of UNITAID's contribution:

- from the indicator we cannot distinguish between patients on 1<sup>st</sup> or 2<sup>nd</sup> line ARVs; and
- the indicator accounts for the people that were placed on treatment in 2008, 2009 and 2010 as well as in previous years.

Additionally, only three countries reported an indicator which referred to children being treated with ARVs (Burkina Faso, India and Serbia<sup>50</sup>). Thus, the actual results for these three countries were compared against the UNAIDS 2010 estimates of paediatric HIV.<sup>51</sup> For the other countries under the paediatric HIV treatment niche, the national indicators referred to all HIV patients (adults and children). Thus, we assumed that the UNITAID Round 6 target referred to both adults and children and compared the UNITAID contribution against the number of people on treatment (as per UNAIDS 2011).

Figure 5.3 illustrates the contribution of UNITAID funding. Key points to note are as follows:

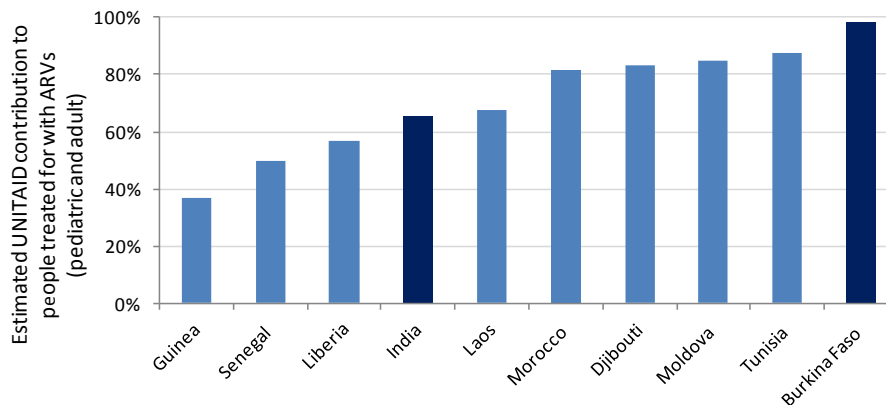
<sup>49</sup> Namibia has not been included in the graph; we consider Namibia an outlier because UNITAID's contribution reached more than 100% of total cases reported. A possible explanation for this is that Namibia has been moving toward malaria pre-elimination and a number of cases might have not been reported.

<sup>50</sup> Although no progress was reported for Serbia so this is not included in our analysis. In addition, the UNAIDS data did not have numbers for Zanzibar, therefore we are not able to report on the progress for this country.

<sup>51</sup> Source: UNAIDS (2010, AIDSInfo dataset – available at <http://www.aidsinfoonline.org/> (Indicator: total number of children aged 4-14 receiving ARV; 2010 Estimates).

- In the 12 countries to which UNITAID contributed resources for HIV treatment, almost 69,000 people were reported as being on treatment in 2010 (adults and children). UNITAID’s contribution supported 40,071 people for treatment i.e. 58%.<sup>52</sup>
- Treatment coverage was higher in the two countries (Burkina Faso and India) where UNITAID funding was directed at paediatric treatment only. In particular, UNITAID supported 98% of children on ARV treatment in Burkina Faso and 66% in India.
- In countries where UNITAID’s contribution provided 2<sup>nd</sup> line ARVs for all HIV patients (both adults and children), UNITAID resources contributed to 69% of all people on treatment in 2010.

Figure 5.3: UNITAID contribution to people (children and adults) treated with ARVs



Notes: Dark-blue columns are those who received paediatric ARVs and reported the number of children treated. Light-blue columns are those countries whose indicators refers to both adults and children on ARVs.

### 5.2.3. Additionality

In this section, we comment on the additionality of the UNITAID funding to Global Fund Round 6. In our assessment, there are several aspects of additionality of the funding as described below.

The Global Fund that Round 6 had already commenced at the time of the discussions on the MoU and hence some of the country grants had to be re-programmed and scaled-up to account for UNITAID support. This suggests that UNITAID support was additional – in that it represented an ‘add-on’, supplementing the existing country grants.<sup>53</sup>

The UNITAID funding can also be considered additional from a technical perspective, in that it was provided at a time when the problem of MDR-TB and HIV-resistant drugs was beginning to be recognised by the global health community, with the markets for second-line therapies being small and treatments extremely expensive. For example, MDR-TB treatment is 50-200 times the

<sup>52</sup> It should be noted that the original targets for HIV (2<sup>nd</sup> line and paediatric) were much higher because they included the targets under the Mozambique grant which was later not availed of. This greatly reduced the overall target for the two treatment niches from 367,026 to 37,026.

<sup>53</sup> The MoU also notes that UNITAID funds will be used “in a manner that is clearly additional and results in a significant increase in the number of patients under treatment compared to current levels of patients being treated in existing grants through Global Fund Rounds 1-5”.

cost of first-line therapies and administered over a longer period of time. Therefore, through this project UNITAID specifically aimed to support second-line treatments which were not yet being funded by other donors. Thus UNITAID’s contribution can be considered additional in that it helped countries access new and expensive MDR-TB drugs and 2<sup>nd</sup> line ARVs as they were being introduced.

Further, based on data provided to us by the Global Fund, we understand that a total of US\$91.2m was spent on treatment in Round 6 (31% of which was from UNITAID) and that overall this money reached a total of 8.5m people with treatment drugs (4.6m or 54% of which can be linked to the UNITAID contribution). As such therefore, while not directly comparable<sup>54</sup>, UNITAID’s contribution was a key source of funding for treatments in Round 6.

*Table 5.4: UNITAID and non-UNITAID contribution*

Item	Total Round 6 treatment	Non-UNITAID contribution	UNITAID contribution
Amount spent on treatment (US\$)	91.2	61.8	29.4
Number of people reached with treatment (millions)	8.5	3.9	4.6

*Source: CEPA communication with the Global Fund*

### 5.3. Efficacy of M&E systems

In this section, we review the efficacy of the M&E systems for the project. As discussed in Section 3, there was a mismatch between the design of the funding and the proposed M&E arrangements, resulting in the successive progress reports not providing any useful information (from UNITAID’s perspective) on the use and impact of their contribution.<sup>55</sup> While the Global Fund submitted the progress reports on time, we note that M&E for the project has been a key challenge, resulting in considerable transaction costs for both organisations. We summarise the key issues below.

*The progress reports did not allow for an assessment of the progress made under the UNITAID grant.*

The attribution challenge was clearly accepted by UNITAID – the MoU noted that the results reported by the PRs will reflect the Round 6 grants as a whole (including the UNITAID funding). However we understand from discussions with UNITAID, that at the time of MoU signing, it was agreed that the Global Fund would develop a way to monitor the UNITAID

<sup>54</sup> It is important to note that the data between the UNITAID and non-UNITAID contribution to Round 6 is not directly comparable. The following assumptions need to be noted: (i) there are a lot more malaria grants in UNITAID’s Round 6 component, which would typically reach a lot more people for a much lower cost/person than TB or HIV would do; (ii) countries selected are not comparable either: UNITAID group involved mainly African countries whereas the large ones in non-UNITAID Round 6 are Ukraine, Cuba and Bangladesh, where arguably treatment costs could be higher; (iii) the sample is not big enough to find suitable comparisons; (iv) treatment targets are in all cases not 100% attributable to the Global Fund or UNITAID financing, with other sources of funding contributing to the results, and different levels of Global Fund investment in other non-procurement costs for treatment services.

<sup>55</sup> As agreed in the MoU, the Global Fund was responsible for the submission of semi-annual updates on project progress and procurement, as well as annual financial and programmatic reports to UNITAID.



funds (e.g. by undertaking more in-depth country-level analysis). However, this did not transpire, and the Global Fund progress reports over the years did not allow for an assessment of the UNITAID contribution. From the Global Fund's perspective, we understand that their accounting and monitoring processes do not allow for individual donor-wise reporting.

As such therefore, the data provided in the programmatic, procurement and financial updates did not relate specifically to the UNITAID funding and it was difficult for the UNITAID Secretariat to track progress in the use and impact of the funds.

*There was no linkage between the programmatic and procurement reports submitted by the Global Fund*

The procurement of drugs reported in the annual reports did not relate to the programmatic results (i.e. targets achieved). For example, in the final procurement report (May 2013) we note that for some countries, their procurement expenditures exceeded the MoU allocations, however the results achieved in terms of number of people treated was substantially lower than the target (e.g. Benin reported procurement for US\$248k for MDR-TB drugs, as opposed to US\$31,504 estimated in the MoU, but only achieved 65% of its target).

*There was inconsistency in reporting in successive annual reports<sup>56</sup>*

There were a number of inconsistencies between successive annual reports. Some of these inconsistencies relate to changes in targets, which were not communicated to UNITAID; while others perhaps relate to mistakes/ omissions (e.g. the final procurement report (May 2013) does not include Cambodia, despite this being a grant under the MoU).

*Treatment indicators were not defined in a standard manner – reflecting Global Fund's penchant to use country indicators to reduce burden, however causing issues in analysis*

The treatment indicators under each grant are national level indicators and therefore not standardised. For example, the malaria indicator for Namibia reports both “number of uncomplicated and severe malaria cases treated”, however the treatment indicator for Guinea only reports “number of uncomplicated malaria cases treated in health centres according to national policy”. Additionally, under the paediatric ARV treatment niche, only three countries (Burkina Faso, India and Serbia) had indicators that reported the number of children being treated with ARVs, whilst the other countries tracked indicators on number of adults and children. Similar issues are encountered across the three treatment niches.

Although the use of national indicators was noted in the original MoU and is an important policy for the Global Fund in order to reduce country burden in reporting against its grants, the lack of standardisation causes a challenge in conducting meaningful analysis of public health impact (as also experienced in our analysis in Section 5.2.2).

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<sup>56</sup> We appreciate that some of these discrepancies in data could have resulted from a restructuring of the Global Fund's procurement data management system – in 2009, the Global Fund's Price Reporting Mechanism (PRM) was replaced by the Price and Quality Reporting (PQR). Consultations with the Global Fund also confirmed that checks/ review of the PQR was much weaker at the start of the implementation of the UNITAID project, and in 2010 a major 'clean up' exercise was undertaken to ensure data consistency, and to verify actual expenditures from PRs.

*There was limited follow-up to address reporting issues*

Discussions with the UNITAID Secretariat suggest that there was limited follow-up by the Global Fund to address key issues with the progress reporting. This is also evident from the successive progress reports, given that type of information presented in progress reports has remained broadly similar over the years. While some issues were addressed by the Global Fund at the start of the project (e.g. UNITAID's suggestion of providing procurement and financial reports as Excel spreadsheets, rather than PDF format), others continued throughout the project – mostly in terms of lack of information and assessment of key issues relating to the market dynamic component of the project (price, availability, quality and delivery) for all treatment niches; and inconsistencies in the programmatic and procurement reporting. In addition, we understand that the Secretariat requested for certain clarifications on the reporting, which were not answered – e.g.:

- Lack of clarity on whether sufficient younger children are being supplied paediatric ARVs (smaller dosages), since substantial treatment seems to be provided for older populations, which could be older children or adults.<sup>57</sup>
- Procurement of drugs which were not specifically listed in Exhibit 2 of the MoU.

Annex 6 presents a summary of key points of review noted by the UNITAID Secretariat over the years on the Global Fund progress reports.

Overall, consultations suggest that a considerable amount of time and resources were expended by both organisations in managing the M&E for this project, resulting in high transaction costs on both sides.

#### **5.4. Project sustainability**

Our intended approach to assessing project sustainability was in terms of the sustainability of UNITAID's funding to the Global Fund – rather than Global Fund funding to the PRs (which would be an extensive undertaking on its own). We had proposed to review both: (i) programmatic sustainability (i.e. the degree to which approaches under the grant (e.g. procurement models, reporting systems) as well as any benefits (e.g. price reductions) could be/have been sustained under the project); and (ii) financial sustainability (in terms of UNITAID funding to the Global Fund).

However, given the experience with this project, there are no programmatic elements that need to be sustained (no procurement model was adequately adopted, M&E systems were challenging). On financial sustainability as well, UNITAID does not intend to support Global Fund through its round-based funding to countries in the future, and rather, focus on more strategic projects in line its market and public health objectives.

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<sup>57</sup> UNITAID market assessment, semi-annual 2009 document.

## 6. CONCLUSIONS AND RECOMMENDATIONS

In this final section, we present our overall conclusions on the End of Project evaluation of UNITAID funding for Global Fund Round 6. As described in Section 2, we have followed the OECD DAC criteria (relevance, effectiveness, efficiency, impact and sustainability) to summarise our findings. We also present some recommendations based on the lessons learnt from this project.

### 6.1. Summary findings

#### *Relevance*

At a high-level, the objectives of the UNITAID contribution to the Global Fund Round 6 were closely aligned with its overall objectives of scaling-up access to treatment and reducing drug prices. However, the design of the project has not supported the achievement of its intended objectives – particularly in terms of the market impact objective, as the project funding was spread too thinly across many drugs for three treatment niches and many countries, without any clearly thought out strategy on how market impact would be delivered.

In addition, a number of other features of the grant were not adequately designed (e.g. the market mechanisms of pooled procurement and reference prices were not clearly enumerated, there was a lack of detailed guidance on implementation and M&E). Therefore, the project – and the experience with de facto implementation – has had reduced relevance in terms of contribution to UNITAID’s goals and objectives. The project has however been recognised as a ‘legacy project’ between UNITAID and the Global Fund, helping to lay the foundation for ongoing collaboration between the two organisations, and in this respect, the project can be viewed as having had an important role.

#### *Effectiveness and efficiency*

Weaknesses in project design have resulted in delayed timelines, which have together contributed to several issues in implementation, as follows:

- While the overall timeline for implementation was aligned with the Global Fund project cycle and country proposals, the project as a whole performed poorly with respect to timeliness. In particular, the original MoU was also signed one year after discussions commenced; and the project as a whole was extended by 2.5 years due to some countries not being able to achieve their targets within the original timeframe; inconsistencies in reporting M&E information; and differing views on calculating the project unexpended amount. The long implementation timeframe of the project contributed to loss of institutional memory within both organisations.
- The two market mechanisms of pooled procurement and reference prices were not adequately designed, resulting in their limited/ no implementation. In particular, the Global Fund did not actively pursue pooled procurement under the project, and the limited pooled procurement that did take place under the project was mostly ad hoc and supported by mechanisms that were established independently of this project (e.g. MDR-

TB drugs procured by GDF). There were diverging views on how the reference price mechanism would be implemented, with long timeframe for the implementation of the project and consequent changes in staff working on the project at both the Global Fund and UNITAID contributing to the confusion

- Budget and financial management did not work very effectively, especially given the substantial allocation to one country (one quarter of funds to Mozambique) that was not eventually utilised nor re-programmed. A single disbursement from UNITAID to the Global Fund, while beneficial for the Global Fund, did not allow UNITAID to link its payments to results (as is the approach at present). Further, a lack of agreement on the approach to calculating the unexpended amount, have resulted in considerable transaction costs for both organisations, with potential implications for the implementation of the AMFm (given the plans to transfer any unexpended amount under the project to AMFm).
- Project management was far from optimal with a lack of clarity in roles and responsibilities and limited collaborative working. There was limited and ineffective communication between the two organisations to address emerging issues and challenges (e.g. key M&E and reporting issues were not followed up by the Global Fund; there was insufficient information from the Global Fund on country grant management; letters from both organisations remained unanswered for months). Approval processes and information exchanges were not always followed as per the specifications in the MoU resulting in data discrepancies throughout the project and considerable additional transaction costs.

In general, our conclusion is that the project has been ineffectively implemented, with much scope for improvement. The five years plus of project implementation have been riddled with high transaction costs, especially during November 2010 when the project was extended and more recently when the two organisations are attempted to consolidate and close the project.

#### *Impact and sustainability*

Our impact analysis was constrained by the lack of an ex-ante results framework for the project as well as inadequate and inconsistent data presented in the progress reports for the project. In particular, the reporting formats were set up in a manner that did not allow for: (i) an understanding of the contribution of UNITAID's funding; and (ii) any linkages between the programmatic, procurement and financial reports (thereby causing issues in interpreting the reported progress).

Our review of the final reports indicates that project achievements in terms of number of people treated was considerably lower than the intended target (commensurate with the lower than planned spend under the project). Overall, 4.6m people were treated over 2007 to 2012 (i.e. 40% of the originally planned target). A further examination of the reported access numbers in comparison with the total number of people treated in a country over the 2008-10 time period suggests that UNITAID funds contributed to reaching around 34% of the total people on treatment for HIV, MDR-TB and malaria in the public sector across the 37 countries during that period. However, the inadequate design of the market-based approaches, coupled with

incomplete procurement reporting has constrained us from undertaking a detailed and comprehensive market impact analysis.

In terms of additionality, UNITAID support to Round 6 could be considered additional, in that some of the Round 6 grants were re-programmed and scaled-up to account for UNITAID support. Also, from a technical perspective the UNITAID funding helped countries access significantly more expensive combinations of therapies for MDR-TB and HIV in response to the emerging threat of drug resistance for both of these diseases.

## **6.2. Lessons learnt and recommendations**

In this section, we set out our recommendations, based on the conclusions and lessons learnt from the project. These recommendations may serve as guidance for UNITAID funding for Global Fund going forward as well as its funding for other grantees.

An important caveat is that our recommendations do not take account of the developments in UNITAID's strategy over the years as well as its experience with other grantees – and hence we recognise that some of our thoughts below may not be very relevant or already adopted approaches. Further, our recommendations are at the high level only and we do not provide an appraisal of possible options or a detailed action plan for the implementation of the recommendation, both of which would be areas for further work.

Key points from our assessment are as follows:

*UNITAID should adopt a more strategic and detailed approach to identifying and selecting projects for support.*

UNITAID is a global health partnership with a focused mandate to leverage price reductions for improved access to HIV/AIDS, malaria and TB commodities. As a funder/ donor in public health, its role is different from that of traditional bilateral or multilateral donors, in that its funding is specifically aimed at bringing about improvements in the three diseases in line with its strategic objectives. Thus it is important that UNITAID focus its funding on projects that will contribute to its overall mission, goals and objectives.

In this regard, we note that the new UNITAID 2013-16 strategy provides detailed guidance on the prioritisation of UNITAID funding, including evaluation criteria for project selection. This includes various rounds of project reviews to ensure there is full alignment between the UNITAID mandate and the project design. We understand that such a strategic approach was not yet in place at the time of the Global Fund Round 6 project. This is therefore an important development in UNITAID's strategy and should be kept under regular review to ensure it is relevant and responsive to the evolving needs of the organisation.

*Project MoUs need to be sufficiently clear and detailed – but at the same time afford flexibility to facilitate implementation and encourage innovations.*

As noted, the MoU for this project was poorly designed and lacked the operational provisions to ensure effective project implementation. Based on the learnings from this project, it would be critical to ensure that project MoUs are sufficiently detailed, and in particular, clearly set out (amongst others):

- The intended activities under the project – their structure, approach, roles and responsibilities of stakeholders.
- A results framework with a logframe of activities-outputs-outcomes-impacts, related targets and milestones, M&E formats and processes. An agreed approach to assess UNITAID’s contribution should be set out upfront. In addition, it would be important to consider some relevant key performance indicators (KPIs) to manage grant implementation and management (e.g. timeliness of submission of progress reports, number of clarifications/ queries addressed and outstanding).
- Risk mitigation and accountability measures – e.g. a phased disbursement process based on results achieved and project requirements, provisions for contingencies, approach to managing delays and extensions.

We understand that UNITAID’s project MoUs are much more detailed today and include the key provisions outlined above.

At the same time, for the successful implementation of a project it would also be important for the MoUs to not be very prescriptive and leave room for implementation to be guided by experience (also to encourage innovation). Thus project MoUs need to reflect an appropriate balance between detail and flexibility.

In addition, it may be useful to introduce some simple and efficient mechanisms to allow for reasonable changes to be made to project activities – in the event that there are any major issues or course correction is required. For example, if the agreed formats for M&E are not useful, the partners should engage in a discussion to agree and implement a revised format. Allocations for countries may be re-programmed if not utilised as per the original intension.

A mid-term review is important to review project progress, but more generally as well, achievements against project targets should be actively monitored (e.g. at the mid-point of the Round 6 project, only 9 of 43 grants were achieving more than 50% of their targets) and options to make appropriate changes should be considered.

*Consider adopting a ‘light touch’ institutional mechanism for the project to improve ongoing collaboration as well as review progress*

There was lack of effective ongoing collaboration and communication between the two organisations throughout the project. Thus in our view, setting up a ‘light touch’ institutional mechanism (such as a Steering Committee or Advisory Group) for the project, comprising representatives from both organisations as well as potentially independent members, could help foster effective ongoing collaboration towards the project objectives. This would also help in resolving key bottlenecks encountered during the project, and provide oversight and guidance on implementation.

Our view is that such an approach might be appropriate for UNITAID (as compared to other bilateral donors that may be funding Global Fund) given its specific strategic mandate to impact public health and market dynamics for the three treatment niches. However, it is important that such a mechanism should not result in substantial additional transaction costs.

*It would be useful to adopt a 'log of changes' for a project to ensure any updates are adequately documented*

Lack of institutional memory resulting from high personnel turnover in the Global Fund and restructuring/ institutional developments in UNTAID, compounded by the delayed timelines, was a key limitation in project implementation.

In general, long-term projects are exposed to greater risk of loss of information due to staff changes and loss of institutional memory, especially over non-formally documented changes and agreements. We suggest that an internal log of agreement be set-up within each organisation to document any agreed requests and approved changes, thereby reducing the risk of loss of critical information whilst also ensuring tracking of the discussions and agreements is maintained.



**UNITAID**

**END OF PROJECT EVALUATION OF SUPPORT TO THE GLOBAL  
FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA ROUND 6**

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6<sup>th</sup> September 2013

**Annexes**

Submitted by:

**Cambridge Economic Policy Associates Ltd.**

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## **ANNEX 1: BIBLIOGRAPHY**

This annex presents a list of key documents and datasets referred to for the assignment.

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- <http://www.who.int/tb/country/data/download/en/index.html>
- WHO (2012) Global TB Report, available at [http://www.who.int/tb/publications/global\\_report/gtbr12\\_main.pdf](http://www.who.int/tb/publications/global_report/gtbr12_main.pdf)
- UNAIDS (2010), AIDSInfo dataset – available at <http://www.aidsinfoonline.org/> (Indicator: total number of children aged 4-14 receiving ARV; 2010 Estimates).

## ANNEX 2: CONSULTEE LIST

Table A2.1 lists the consultations carried out for the assignment.

*Table A2.1: Consultations list*

Organisation	Name and position
UNITAID	Ambachew Medhin Yohannes, Current Manager for Global Fund Round 6
	Cecil Langley, Finance Officer
	Gauri Khanna, M&E Technical Officer
	Imelda de Leon, former Grant Manager of the UNITAID Round 6 grant
	John Cutler, Malaria Portfolio Manager
	Kate Strong, M&E Officer
	Philippe Duneton, Deputy Executive Director
Global Fund	Di Wu, Senior Program Officer, South East Asia Team
	Graham McNeill, Senior Manager, Donor Governments Team
	Jan Van Damme, Donor Relations Officer, Donor Governments Team
	Martin Auton, Senior Technical Officer, Voluntary Pooled Procurement Team
	Matias Gomez, Senior Manager, Operational Policy & Process Support Team
	Nathalie Zorzi, Manager, Monitoring Hub Team
	Sophie Logez, Procurement Hub Team

### ANNEX 3: COUNTRY FOCUS FOR THE PROJECT

This annex presents the country allocations as per the Memorandum of Understanding (MoU) used to assess the alignment with UNITAID's eligibility criteria (Table A3.1). It also examines the country allocation based on the revised income classification at the end of project closure in December 2012 (Table A3.2).

Table A3.1: Country allocations as per the MoU

Treatment Niche	Country	Grant Number	World Bank classification in FY07 (March 2006)	Allocation (US\$m)	% of total project
Pediatric ARV	Burkina Faso	BUR-607-G06-H	LIC	600,000	1.14%
Pediatric ARV	Guinea	GIN-607-G04-H	LIC	66,000	0.13%
Pediatric ARV	Laos	LAO-607-G08-H	LIC	1,651	0.00%
Pediatric ARV	Mozambique	MOZ-607-G05-H	LIC	6,450,000	12.29%
HIV	Liberia	LBR-607-G04-H	LIC	240,529	0.46%
HIV	Mozambique	MOZ-607-G05-H	LIC	7,329,958	13.97%
HIV	Zanzibar (Tanzania)	ZAN-607-G05-H	LIC	13,109	0.02%
ACTs	Bangladesh	BAN-607-G07-M	LIC	315,875	0.60%
ACTs	Cambodia	CAM-607-G10-M	LIC	888,143	1.69%
ACTs	Eritrea	ERT-607-G05-M	LIC	577,978	1.10%
ACTs	Gambia	GMB-607-G04-M	LIC	3,428,900	6.53%
ACTs	Guinea	GIN-607-G05-M	LIC	6,952,344	13.25%
ACTs	Guinea Bissau	GNB-607-G04-M	LIC	1,141,226	2.17%
ACTs	Mali	MAL-607-G04-M	LIC	2,992,062	5.70%
ACTs	Mauritania	MRT-607-G04-M	LIC	2,300,758	4.38%
ACTs	Somalia	SOM-607-G04-M	LIC	31,062	0.06%
MDR-TB	Benin	BEN-607-G06-T	LIC	31,504	0.06%
MDR-TB	Kyrgyzstan	KGZ-607-G04-T	LIC	2,501,651	4.77%
MDR-TB	Rwanda	RWN-606-G07-T	LIC	326,749	0.62%
MDR-TB	Tajikistan	TAJ-607-G06-T	LIC	126,000	0.24%
MDR-TB	Tanzania	TNZ-607-G09-T	LIC	126,000	0.24%
Pediatric ARV	India	IDA-607-G11-H	LIC	4,444,445	8.47%
Pediatric ARV	Senegal	SNG-607-G05-H	LIC	271,200	0.52%
HIV	Laos	LAO-607-G08-H	LIC	10,532	0.02%
HIV	Moldova	MOL-607-G03-H	LIC	732,283	1.40%
ACTs	Côte d'Ivoire	CIV-607-G06-M	LIC	813,657	1.55%
MDR-TB	Bhutan	BTN-607-G04-T	LIC	99,000	0.19%
MDR-TB	India	IDA-607-G09-T	LIC	958,126	1.83%
MDR-TB	Moldova	MOL-607-G02-T	LIC	1,264,958	2.41%
MDR-TB	Vietnam	VTN-607-G05-T	LIC	823,381	1.57%
Pediatric ARV	Morocco	MOR-607-G02-H	LMIC	37,200	0.07%
HIV	Djibouti	DJB-607-G04-H	LMIC	117,600	0.22%

Treatment Niche	Country	Grant Number	World Bank classification in FY07 (March 2006)	Allocation (US\$m)	% of total project
ACTs	Djibouti	DJB-607-G02-M	LMIC	49,708	0.09%
MDR-TB	Egypt	EGY-607-G02-T	LMIC	522,000	0.99%
MDR-TB	Georgia	GEO-607-G05-T	LMIC	1,836,800	3.50%
MDR-TB	Guatemala	GUA-607-G03-T	LMIC	55,707	0.11%
MDR-TB	Sri Lanka	SRL-607-G07-T	LMIC	292,200	0.56%
MDR-TB	Syrian Arab Republic	SYR-607-G01-T	LMIC	180,082	0.34%
Pediatric ARV	Serbia	SER-607-G03-H	LMIC	104,000	0.20%
HIV	Tunisia	TUN-607-G01-H	LMIC	252,270	0.48%
ACTs	China	CHN-607-G09-M	LMIC	179,100	0.34%
ACTs	Namibia	NMB-607-G06-M	LMIC	1,875,000	3.57%
MDR-TB	Belarus	BLR-607-G02-T	LMIC	549,720	1.05%
MDR-TB	Bulgaria	BUL-607-G02-T	LMIC	229,446	0.44%
MDR-TB	Kazakhstan	KAZ-607-G02-T	LMIC	332,000	0.63%

Source: UNITAID reconciliation statement

While the MoU clearly states that country eligibility will be based on the income status at the time of the call for Round 6 proposals in March 2006 (and that subsequent changes in country income status, while to be noted, will not impact the funding allocation), we have also examined the country allocation based on the income classification of the 38 countries at the end of the project i.e. as of December 2012 (Table A3.2). As per the updated classification, seven countries have graduated to UMIC status, with another nine graduating to LMIC, implying that at the end of the project, the amount spent on LICs is only 48.9%.

Table A3.2: Analysis of country allocation (based on 2012 country income classification)

Expenditures	LICs	LMICs	UMIC
Final expenditure (based on UNITAID reconciliation statement)	13.2m	11.0m	2.7m
Percentage of funding spent	48.9%	41.0%	10.1%

Source: CEPA's calculations based 2013 UNITAID reconciliation statement of final expenditure

## ANNEX 4: ADDITIONAL ANALYSIS ON THE ACHIEVEMENT OF THE TARGETS

This annex provides some additional analysis on the achievement of targets under the project.

Key points to note are as follows:

*The pace at which countries have achieved their planned results in terms of numbers of people treated has varied substantially, with slower than planned progress for a number of countries*

In March 2009 at mid-implementation of the original closing date of the grant, the second annual programmatic progress reported that only two grants had achieved 100% of the original target, whilst a third of the grants (15 grants) had achieved 0% of the original target. The progress of the 43 grants is reported in Table A4.1.

*Table A4.1: Progress of grants as per the second annual progress report*

Indicator	Number of grants
Number of grants achieving 100% of target	2
Number of grants achieving between 51% and 99% of target	7
Number of grants achieving between 1% and 50% of target	18
Number of grants achieving 0% of target	15
Number of grants not availed of (i.e. Mozambique)	1
Total number of grants	43

*Source: CEPA analysis from Global Fund second annual programmatic progress report (March 2009)*

*The extension provided in November 2010 was useful to help 13 grants achieve their objectives*

We note that of the 22 grants that were extended in November 2010, 13 achieved their objectives by the project end date in December 2012, whilst nine grants were unable to achieve their objectives. This is shown in Table A4.2.

*Table A4.2: Number of grants which achieved their targets following the extension*

Indicator	Extended in November 2010	Targets achieved by December 2012	Targets not achieved by December 2012
Number of grants	22	13	9

*Source: CEPA calculations based on Global Fund end of project report and UNITAID reconciliation statement*

## **ANNEX 5: METHODOLOGY AND LIMITATIONS FOR THE PUBLIC HEALTH IMPACT ASSESSMENT**

This annex sets out the methodology and limitations for the public health impact assessment presented in Section 5.2.2. of the main report. We present the overall assumptions in the methodology, followed by the assumptions for each treatment niche.

### **1. Overall assumptions**

There are a number of assumptions employed in our methodology to estimate UNITAID's contribution against the overall burden of disease at the national level during the original Phase I grant period (2008 to mid-2010). These are as follows:

- There are a number of factors, beyond the control of UNITAID, which could potentially influence whether or not funds provided to the Global Fund were translated into patients receiving treatment. These factors include issues that could affect the process of procuring and distribution of drugs at international, national, health facility, household and the individual level.
- Given different lead times, and length of drug regimens (from three days for malaria, 18 months for MDR-TB and lifelong for ARVs) a specific cut-off date is difficult to determine. For the purposes of this evaluation, reported cases for each disease are calculated based on the assumption that countries received treatments funded by UNITAID's contribution to the Global Fund between 2008 and end-2010 (mid-2010 for malaria).
- Given that UNITAID funds are provided in addition to other resources in countries, the estimates provided in our analysis should be interpreted with caution, taking into account that overall impact is not directly attributable to UNITAID.

### **2. Treatment niche specific assumptions/ limitations**

#### *HIV/ AIDS*

- Calculations for HIV/AIDS are based on the assumption that ARV is a continuous treatment, and thus, our estimates do not account for changes in treatment for patients' changing conditions or drug resistance.
- The UNITAID contribution is assessed against the "reported number of people receiving antiretroviral therapy in 2010". Given the continuous nature of the treatment, this indicator not only includes people on treatment in 2008 and 2009 but also in previous years.
- It is also assumed that most HIV cases are treated in the public sector.

#### *MDR-TB*

- Calculations for MDR-TB are based on the assumption that most MDR-TB cases are treated in the public sector.



- In addition, evidence suggests that a large proportion, as high as 93%, of TB and MDR-TB cases remain undetected and untreated (Nathanson, 2010). Thus, calculations for this evaluation should more accurately be described as UNITAID's contribution to increasing access to treatment for all identified cases of MDR-TB. Based on this, any UNITAID contribution is an overestimate as the true burden is underestimated – the degree to which this is the case is highly variable between countries depending on the strength of their health systems.
- The total number of reported cases for MDR-TB is based on the assumption that TB patients continued to be treated past mid-2010 when the grant was officially closed.

### *Malaria*

- While patients frequently seek treatment for malaria in either or both the private and public sector, for the purposes of this evaluation, only probable and confirmed malaria reported in the public sector are considered. This due to the large variation in estimations between different models used to predict the true burden of malaria disease (for example when comparing Cibulskis, 2009 and Murray, 2010). The impact of this is that the contribution of UNITAID is likely to be an overestimation relative to the true burden of disease.
- In three countries, Mali, Cote D'Ivoire and the Gambia national indicators under the UNITAID Round 6 grant applied to the treatment of children under-5 only. In order to estimate the likely proportion of the total reported cases attributable to under-5s using the Malaria Atlas Project risk maps (<http://www.map.ox.ac.uk/>), the transmission intensity of malaria in each country was considered and proportion of cases in under-5s estimated. For Mali and Cote D'Ivoire, we considered a high transmission setting – where transmission occurred, it was estimated that 60% of total reported cases were attributable to children under-5. In Gambia, where transmission is considered relatively low, it was estimated that 25% of total reported cases were attributable to under-5s.

## ANNEX 6: SUMMARY OF SECRETARIAT REVIEWS OF GLOBAL FUND PROGRESS REPORTS

This annex summarise the key points of review noted by the UNITAID Secretariat on the Global Fund progress reports over the years. These are summarised in line with the Secretariat's internal review formats: (i) market/ procurement assessment; (ii) financial assessment; and (iii) M&E assessment.

### 1. Market/ procurement assessment

- *Lack of clarity on pooled procurement actions.* Reports were silent on specific actions related to pooled procurement activities. UNITAID commented that reference to direct disbursement by the Global Fund to manufacturers to minimise transaction costs cannot be referred to as pooled procurement.<sup>1</sup>
- *Insufficient information on low rate of uptake of UNITAID funds.* For example, in the 2<sup>nd</sup> Annual Progress Report (2009), the total expenditure for the products during the period was only US\$ 2.6m across all niches, but the amount of money disbursed by UNITAID for the two years was US\$52.5m.<sup>2</sup>
- *Deviation from product specification.* Some products procured were not included in the proposal/ MoU. UNITAID suggested the need to stick to the list provided or obtain advance authorisation from UNITAID prior to proceeding with procurement.<sup>3 4</sup>
- *Product availability.* No information on supply and demand was identified in the report, and stock-out situations were not reported.
- *Lack of differentiation between first and second line treatment niches for ARVs.* Figures reported reflected total number of people receiving ARVs in the beneficiary countries without differentiating between first and second line treatment recipients, making it difficult to identify whether procurement was conducted either for paediatric or second line therapy, and under which niche headings were allocated (e.g. for Laos).
- *Reference prices.* For TB and malaria, UNITAID suggested that the Global Drug Facility (GDF) and UNICEF prices be used as baseline prices.<sup>5</sup>

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<sup>1</sup> For example, for the 2<sup>nd</sup> semi-annual procurement update, there was a reference to the process of procurement without a description of the actions that were taken to procure medicines in this time period.

<sup>2</sup> Review of 2<sup>nd</sup> Annual Progress Report.

<sup>3</sup> For example, of the 7 countries eligible for ARV procurement, only four reported procurement, but these reported substantial deviations from Exhibit 2 of the MoU. Further, in the 4<sup>th</sup> Semi-annual project and procurement report, UNITAID asked the Global Fund to submit a revised list of drugs and formulations in Exhibit 2 to take into account the drugs that are currently being procured but not included in the MoU.

<sup>4</sup> 3<sup>rd</sup> annual progress report (Jan-Dec 2009)

<sup>5</sup> The Global Fund recipients procure anti-TB drugs from the Global Drug Facility (GDF) and thus benefit from GDF negotiated medical prices like all UNITAID's TB projects. A similar situation exists with UNICEF for ACTs with all countries paying the same prices for medicines. However, prices of ARVs vary widely according to country income status, product type, registration practices, etc, and also designating a reference price for these medicines is complicated by a lack of harmonised and comparable information. UNITAID is actively working with WHO, CHAI, and the Global Fund among others to harmonise the way price data for ARVs are captured, tracked through

## 2. M&E assessment

- *Difficulty in attributing UNITAID impact.* Due to collective attribution, it was not possible to isolate UNITAID contribution and track it to beneficiaries.
- *Lack of information on market impact.* An assessment related to UNITAID's market dynamic impact (availability, price, quality and delivery) was not measureable from information in the reports. It was suggested that using the UNITAID reporting template may enable a better understanding of these areas for the future.<sup>6</sup>
- *Lack of harmonised indicators and methodology for country reporting.* Given that countries were reporting slightly different versions of the same indicators, it was difficult for the Global Fund to compare what countries are reporting at one point in time, which makes it difficult for the UNITAID Board to harmonise reporting indicators across all projects.<sup>7</sup> UNITAID commented that effort should be made to harmonise reporting and to provide an analysis of the data gathered from the PRs for the reporting period. In particular, in terms of the definition of 'people treated', UNITAID noted that in order to compare across countries, it would be useful to have harmonised indicators at least to the extent that it is possible to report 'people treated' instead of a mix of all ages, adults, and under five year olds.<sup>8</sup>
- *Lack of information on implementation issues.* Less clarity on challenges faced in project implementation during Phase I for countries, and action steps taken to avert the risk of not achieving the cumulative targets by the end of year 2.
- *Format of reporting.* UNITAID suggested that it would be helpful to have revised financial and procurement reports as Excel sheets, as providing this information in PDF format makes it difficult to use and incorporate into UNITAID's own reporting scheme.

## 3. Financial assessment

- *Need for a cost mechanism to validate UNITAID contributions.* UNITAID suggested that a cost mechanism should be considered to make possible appropriation of the disbursements to participating grants among the donors. Validating the financial data for UNITAID part is not feasible with the current reporting. The reports did not have the level of detail to segregate UNITAID portion of expenditure, and do not provide information on what portion of the procured items was disbursed to the participating grants in the reporting period.
- *Format of financial report.* The format of the financial report included all information requested in the MoU, but pooled with other funding sources, so UNITAID support

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time and reported to enable countries to have the required information to negotiate reasonable prices for these medicines. This is work in progress and the outcome will be a set of reference prices for ARVs.

<sup>6</sup> Review of 2<sup>nd</sup> Annual Progress Report.

<sup>7</sup> UNITAID suggested that the Global Fund should refer to the exact definition of indicators per grant given in Annex 3 of the MoU.

<sup>8</sup> The Global Fund reports to UNITAID what it receives from PRs supported by UNITAID funding in Round 6 grants. UNITAID is asked by its Board and donors to report (per calendar year) on: (i) number of patients treated per country; and (ii) the cost spent (US\$) for the number of people treated medicines purchased) per country.

was presented in aggregate with funding from other donors in participating grants. The period expenditure is also pooled.

- *Completeness of financial information.* While the reports provided aggregate information (of UNITAID support and other funding sources for the participating grants) per treatment niche, beneficiary country, sub-total of disbursements per treatment niche, but UNITAID portion was not segregated (this seems not to be feasible according to the available information).

## ANNEX 7: SUMMARY OF UNITAID EXECUTIVE BOARD ‘UPDATE ON OPERATIONS’

This annex presents a summary of key points from the UNITAID Executive Board’s ‘Update on Operations’ with regards to UNITAID funding for Global Fund Round 6. While a number of issues were noted in these updates, we summarise only those points which are relevant for the purpose of our evaluation.

*Table A7.1: Summary of key points from UNITAID Executive Board ‘update on operations’*

Report	Key points to note
June 2010	<ul style="list-style-type: none"> <li>• The recently reported project developments point towards the need to clarify: (i) implications of the consolidation of some Round 6 grants with Round 8; (ii) if the 13 grants that are expected to continue would still be under Phase I; and (iii) the status of the ‘frozen’ grants.</li> <li>• While the UNITAID support for Round 6 funding was expected to reach completion by June 2010, but the programmatic data for the period ending December 2009 would be submitted to UNITAID by 31<sup>st</sup> March 2010. This implies that there will hardly be any window for implementing adjustments, and less proactive project management. Thus, the need for more frequent and timely reporting for future MoU negotiations was emphasised.</li> </ul>
November 2010	<ul style="list-style-type: none"> <li>• The OIG investigation of the ACT grants for Mali and Mauritania underscore the need for appropriate risk management/mitigation provisions in UNITAID’s project MoUs in case similar events arise.</li> <li>• The Global Fund reported total intended target per UNITAID reporting period (as specified in the Performance Update and Disbursement Review (PUDR)) for all treatment niches. However, clarification on the difference between the targets specified in the MoU and the total intended targets per UNITAID reporting period was yet to be received.</li> <li>• The project’s reporting limitations precluded the UNITAID Secretariat to independently estimate the project’s unexpended amount. Due diligence and planning on the part of the UNITAID Secretariat could have been better served had the MoU provided for regular submission of more robust and more comprehensive information.</li> <li>• The Global Fund's decision to not avail of the financial support for Mozambique resulted in a reduction of budget: US\$ 6.45 for Paediatric ARV; and US\$7.3 for 2nd Line ARVs.<sup>9</sup></li> </ul>
July 2011	<ul style="list-style-type: none"> <li>• Due to the limitations of the Global Fund's procurement reporting system, an extension was requested by the Global Fund to reconcile information on funds spent and procurement achieved for the project.</li> </ul>
December 2011	<ul style="list-style-type: none"> <li>• Channelling monies through the Global Fund system helped to strengthen existing country procurement activities without creating new processes.</li> <li>• Operational performance was rated as ‘poor’.</li> </ul>
June 2012	<ul style="list-style-type: none"> <li>• Operational performance was rated as ‘poor’</li> </ul>

<sup>9</sup> Due to a likely risk of duplicate UNITAID funding for Mozambique for paediatric and 2nd line ARVs, a provision for withholding remittance of funds for these niches, amounting to US\$13.8m was incorporated into the project’s MoU. The Global Fund decided not to avail for the funding for Mozambique, since Mozambique requested for a very small amount of US\$ 851 for the procurement of ARVs under Round 6.

Report	Key points to note
	<ul style="list-style-type: none"> <li>• The Global Fund requested and was granted a no cost extension for the project; however, the Global Fund did not yet fully comply with the MoU reporting requirements.</li> </ul>
December 2012 <sup>10</sup>	<ul style="list-style-type: none"> <li>• Operational performance rated as 'poor'</li> <li>• Procurement report and computation of remaining unspent funds was still incomplete. UNTAID requested that the Global Fund report on these issues by the end of December 2011.<sup>11</sup></li> </ul>
June 2013 <sup>12</sup>	<ul style="list-style-type: none"> <li>• Operational performance was rated as 'acceptable'.</li> <li>• The Global Fund did not submit the final programmatic and financial report for the project including the full accounting of unexpended project funds to be refunded to UNTAID in 2012.</li> <li>• In the context of the Executive Board Resolution to provide the remaining unexpended balance from the Global Fund Round 6 project for the AMFm Transition Year 2013, UNTAID is to reconcile the amount of project funds that remain unexpended and ensure that this amount is reimbursed to UNTAID.</li> </ul>

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<sup>10</sup> No cost extension upto 31<sup>st</sup> December 2012 under discussion.

<sup>11</sup> According to UNTAID records, the undisbursed project fund available in the account of the implementer is around US\$11m.

<sup>12</sup> No cost extension granted till May 2013.

## **ANNEX 8: SECRETARIAT NOTES ON KEY POINTS OF CONCERN ON THE PROJECT**

This annex summarises the key points of concern vis-a-vis the Global Fund from internal documentation made available to us by UNITAID.<sup>13</sup>

### **1. Unexpended balance**

The difficulty in reporting of unexpended balance arises from the Global Fund's interpretation that the annual financial reporting of disbursement serves the purpose. However, disbursement reported annually are transfers made from the Global Fund to the PRs, not expenditures made by PRs; and disbursements reported on an annual basis cover the total amount disbursed to PRs, not specifically the UNITAID funds disbursed to the PRs.

### **2. Request to use unexpended funds into Phase 2**

Key issues noted include:

- *Submission beyond project end date, thus potentially disruption delivery.* The Global Fund request for extension was submitted past the project end date. The Global Fund request letter was dated 13<sup>th</sup> July 2010, and received at the UNITAID Secretariat on 22<sup>nd</sup> July 2010.
- *Lack of information to support the required programmatic assessment as articulated in the MoU.* The letter listed the 13 grants for which extension is requested. Information to support the required assessment and the situation of unexpended balance were not presented.
- Omission of discussion of financial and programmatic implications of the request.
- *Contradictory information regarding the extent of achievement of results.* After removing Mozambique grant from the project, UNITAID supported 42 grants. The 13 grants for which extension was requested did not include the two grants that were reported to be under OIG investigation, implying that these were classified within the 29 grants that were considered as having achieved their results. In a letter dated 6 September 2010 from the Global Fund to UNITAID, it was clearly stated that the Mali grant had achieved 582,547 out of a total target of 2,687,876 treatments under Phase I. The ACT Mauritiana grant (also under OIG investigation) is also included in the 29 grants that were considered to have achieved their targets.
- Contradictory results regarding the extent of disbursement of UNITAID funds to PRs.

### **3. Procurement, reporting and Quality Assurance (QA)**

- *Lack of clarity regarding QA status of reported drug purchases being charged to UNITAID.* The UNITAID Secretariat consistently noted procurement of drugs which were not specifically listed in Exhibit 2. Prior communications noted the Global Fund acknowledgement that some procurement was not in line with the agreed QA, and withdrawal of these from those to be charged by UNITAID.

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<sup>13</sup> [to insert full reference of the document]

- There is a need to re-compile periodic reports in light of observations regarding some reported purchases.

#### 4. Limitations of current MoU

- *Financial.* These includes: (i) Lack of tracking and reporting of UNITAID funds disbursed to the PRs and spent by PRs – PRs are required to report total expenditure for pharmaceuticals per grant, but not on total expenditure per grant for each particular product type or niche; and (ii) lack of provision for budget adjustments to reflect actual costs and revised targets.
- *Timeliness of information.* Significant time lag between the cut off dates of PR reporting and the submission of consolidated PR reports to UNITAID.
- *Additionality.* Lack of verifiable quantitative definition of the application of UNITAID principle of additionality to the project. The results reported by the PRs reflect the combined contributions of the Global Fund (including UNITAID project support cost), and any other source of funding (domestic or donors).
- *Eligibility criteria/ cost sharing.* Lack of provision for adjustment mechanism relating to cost sharing in case recipient countries become reclassified to (UMICs or higher).
- *UNITAID visibility.* These included: (i) Disconnect between the grants' specific performance in relation to the UNITAID funded treatments and the Global Fund disbursement process; and (ii) lack of provision that requires that the UNITAID funding contribution be recognised in the participating grants.