Mid-Term Evaluation of the
ESTHERAID Project

Final Report

February 2013

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TABLE OF ACRONYMS

ACAME	Association of African Central Medical Stores for essential Drugs
AFD	Agence Française de Développement
AMDS	Medicines and Diagnostics Service
APS	Appui Psycho Social (Psycho Social Support)
ARV	Anti Retro Viral
ATC	Anonymous Testing Clinic
ATC	Approved Treatment Centre
CAR	The Central African Republic
CDF	Combinaisons à Dose Fixe (French acronym)
CDV	Conseil et Dépistage Volontaires (French acronym)
CENAME	Cameroon National Essential Drugs Procurement Centre
CD4	CD4 lymphocytes
CHAI	the Clinton Health Access Initiative
CMS	Central Medical Store
CNLS	National Committee for the Fight against AIDS (French acronym)
CP	Complexe Pédiatrique /paediatric treatment center of Bangui (French acronym)
CPEA	Chargé de Projet ESTHERAID
CPP	Coordinated Procurement Planning-initiative
DBS	Dry Blood Spot Specimens (HIV drug resistance testing)
DGPML	Direction générale de la pharmacie du médicament et des laboratories, Burkina Faso (French acronym)
DRS	Direction Régionale de la Santé (French acronym)
ETP	Education Thérapeutique des Patients, Therapeutic Patient Education (French acronym)
ESTHER	Ensemble pour une Solidarité Thérapeutique Hospitalière en Réseau (French acronym)
FDC	Fixed Drug combinations
GAPh	Gestion des Approvisionnements Pharmaceutiques (French acronym)
GAS	Gestion des Approvisionnements et du Stockage (French acronym)
GBEA	Guide de Bonne Exécution des Analyses de biologie médicale (French acronym)
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIP	Groupement d'Intérêt Public – Public Interest Grouping (French acronym)
HCB	Hôpital Communautaire de Bangui (French acronym)
HCNLS	Haut Conseil National de Lutte contre le Sida (French acronym)
ITA	International Technical Assistant
IUD	Inter University Diploma
JURTA	Joint UN Regional Team on AIDS
KPI	Key Performance Indicators
LMIS	Logistic Management Information System
LNBCSP	National Laboratory of Clinical Biology and Public Health (French acronym)

MCSA	Mécanisme-Malien-de Coordination et de Suivi des Approvisionnements - Procurement coordination mechanism (French acronym)
MDU	Medicine Distribution Unit/National central medical store
MoH	Ministry of Health
MoU	Memory of Understanding
MPH	Ministry for Public Health, the Population and the Fight against AIDS
NTA	National Technical Assistant
OI	Opportunistic infections
PCR	Polymerase Chain Reaction
PNLS	Programme National de Lutte contre le Sida (French acronym)
PMD	Pharmacy and Medicines Department
PSM	Procurement and supply management
PSSLS	Programme Sectoriel Santé de Lutte contre le Sida, Burkina Faso (French acronym)
PMTCT	Prevention of Mother-to-Child Transmission
PPTCT	Prevention of Parent-to-Child Transmission
PLWHA	People Living with HIV/Aids
TFP	Technical and Financial Partners
RHD	Regional Health Delegation
RUTFs	Ready-to-Use Therapeutic Foods
SCMA	Supply Chain Management Assistance
SCMS	Supply Chain management systems
STG	Standard Treatment Guidelines
TCC	Treatment and Counselling centre
UA	UNITAID
VPP	Voluntary Pooled Procurement
WHO	World Health Organisation

0. EXECUTIVE SUMMARY

The programme under review is the result of a unique partnership, called "ESTHERAID", that brings UNITAID together with the French governmental aid agency ESTHER. ESTHERAID, first programme of its type in West Africa, seeks optimised efficiency from alignment and pooled resources *to trace and ensure delivery of (HIV/AIDS) health products from central medical stores* to local clinics down to the patients.

The review took place mid-December 2012 till mid-February 2013 and did not foresee country visits. It is based on interviews and e-net questionnaires, forwarded through the five country managers.

The programme is **relevant**: the programme design was based on prior assessment (2009) of key stakeholders and bottlenecks in the five programme countries: Benin, Burkina Faso, Cameroon, the Central African Republic (CAR), and Mali.

The programme was to be complementary to the CHAI second-line ARV programme that focused on procurement of second-line treatments and ran from 2007 till December 2011. Despite initial delays and reduced overlap, ESTHERAID picked up where CHAI programme left, on all three of its main objectives: (i) *receipt, (ii) healthcare capacity* to *use the project drugs*, and (iii) *database*.

There are problems challenging the **efficiency**. At programme start (January 2011), reality and project partners had changed in the field, and programme updating was needed before MoUs were signed. Activities started as late as end of 2011 for Cameroon and the CAR. Political instability in the CAR and Mali were further obstacles. By the time activities really took off, CHAI second-line ARV programme had come to an end, and the supplies provided from UNITAID budget weren't available anymore.

The three main objectives of ESTHERAID, (i) supply management, (ii) improved healthcare capacity, and (iii) database for patients and ARVs, required intensive collaboration with the country HIV/AIDS management and structures, and with all the partner organisations. This included the strategy of decentralisation of treatment and care sites in all five countries.

Effectiveness is good in spite of delays and the fact that risks of stock-outs turned true. Trainings were organised in the central stores, distribution centres, tutoring and referral hospitals and laboratories, for all levels of staff, including doctors, nurses, technicians, pharmacists and counsellors. Those trainings, some still going on or just started, include inter-university diplomas for supply management and holistic care for People Living With HIV/AIDS (PLWHA). The trainings were conducted with local and international experts, including from twinning hospitals and internships.

In an environment where staff turnover is high in all 5countries, Training-of-Trainers (ToT) courses will ensure **efficiency** and **sustainability** for the patient database ESOPE, for best practices in managing stock and pharmaceutical supplies, and for psychosocial accompaniment as building-up healthcare capacity, and improving the quality of care. Without ToT programme, results achieved so far, including better quantification and forecasting, could be lost. Staff of teaching hospitals was trained on formative assessment to perform quarterly supervisions at the treatment sites, using an evaluation matrix.

ESTHERAID project activities are *integrated* in the action plan of the Ministry of Health of the recipient countries. There is a strong *involvement of the authorities* in the implementation of project activities. To ensure that pharmaceutical and diagnostic norms and standards persist beyond the

programme, ESTHERAID supported the necessary decrees and the constitution of interagency national procurement and supply management committees, which include stakeholders and ESTHERAID.

On **management**: The programme has been managed transparently for finances and with a comprehensive logical framework. Some managerial hurdles existed as to feedback on reports and release of funds. Key performance indicators of UNITAID and ESTHERAID are not yet completely aligned and do not facilitate real-time monitoring in spite of existing databases.

Another **implementation issue** is that the programme is ambitious in terms of number of participating partners (139), in terms of treatment sites, trainees, and logistic and health systems to upgrade. The short duration (3 years) of this programme, threatens in-depth performance and consolidation of the acquired improvements. ESTHERAID is in the process of requesting a no-cost extension of one year.

ESTHERAID has *no budget to purchase drugs or reagents*. Due to stock-outs, the disruption of supplies, forecasting and efficient distribution has proven to be a challenge in 2011. Improvement was notable in 2012; but much remains to be done. With the improved information systems and database, advances are expected in supply management with accurate forecasting and efficient distribution, leading to less supply shortage.

On **sustainability:** Institutional anchoring of procurement and distribution systems are gradually set in place, and treatment centres are equipped with applied databases and improved quality of care; but the funding for ARVs is not fully secured and is still pending the Global Fund reorganisation process, and networking with other donors. It is not yet clear which role ESTHER will (or expects to) play at this level. But without securing of the supplies, there is no programme and no application of improved systems. ESTHER is, but only recently and because of UNITAID insistent urging, now represented in procurement coordination platforms such as CPP and JURTA.

UNITAID by financing ESTHERAID has made relevant contribution to the demand side, thus complementing other UNITAID projects and increasing UNITAID impact on relevant markets and on public health. As previous UNITAID projects have allowed learning, it is important but not enough to bring low-price supplies into the harbour, it takes much more to get it to the patient.

Summary of the recommendations

To ESTHER:

- Consolidate institutional standards, norms and good distribution practices for pharmacy and laboratory to ensure implementation beyond the programme;
- Finalize the further needs of training and supervision on compliance, education for proper monitoring of those who are already under treatment: pharmaco-vigilance, viral load, computer tools;
- Streamline delays for validation of ToRs and reports, locally and at HQ;
- Improve timeliness of provision of funds to the field;
- Reduce the number of international external consultancy planned. Replace by local or in-house experts and twinning;

- Simplify reporting along key indicators and focus on key themes rather than on countries. This will give a clearer picture of impact and of ESTHERAID' contribution to procurement, distribution and informed use of supplies;
- Many treatment centres could benefit from concentration and comprehensiveness of activities (more in less);
- Although the transition mainly focuses on the improved management, receipt, ordering, and use of drugs and reagents, ESTHER could use its experience, established networking, and implantation in these 5 (and more) francophone African countries, to further advocate and lobby to the governments to have the budgets in place, identified partners and donors as part of the exit strategy, besides consolidating the excellent work that has been done so far. ESTHERAID must ensure that this work is not lost and therefore work to ensure available and accessible drug supply, bulk ordering, and lower prices for medicines through its networking;
- ESHTER could increase its role in market dynamics and procurement coordination and support the role of UNITAID, by being more vocal and increase visibility of ESHTERAID' experience, through dissemination of lessons learned and success stories; and
- Provide UNITAID with the necessary documents demonstrating the extent of ESTHERAID contribution to UNITAID' main objectives, justifying the request for extension of the ESTHERAID project by one year, and including a financial- and work-plan.

To UNITAID:

- Approve extension of project time by one year;
- A key programming lesson is that similar kind of projects should have a duration of 5 years;
- The final evaluation would benefit from country visits. Internet communication is not really functioning in that environment and culture. Interviews of HIV/AIDS programmers and donors will better contribute to understand the constraints, advocate transition and secure budgets; and
- Based on the ESTHERAID project, UNITAID could revisit its model and broaden its vision in terms of market place, considering the importance of the needs for management capacity building, of technical assistance for operational enhancement, and the link with actual impact on public health.

To ESTHER and UNITAID:

- Activate networks and plan fund raising activities to ensure funding and delivery of drugs. Besides the lobbying and advocacy done so far, ESTHERAID and ESTHER could use their influence together with UNITAID to network at high national and international level, and network with donors and FTPs to ensure funding and secure the delivery of accessible drugs;
- Agree and concentrate on common (with UNITAID) limited simple process outcome

indicators and perform real time monitoring and reporting on limited pre-identified indicators;

- Adapt financial reporting and detail committed funds within each reporting period to better inform on progress and levels of consumption of resources; and
- Continue support activities to ensure the effective ordering, receipt and use of drugs (by Training of Trainers, or by inclusion in government programmes).

1.INTRODUCTION

1.1. Background

(1) The French governmental aid agency ESTHER was created in March 2002 to improve access to treatment and quality care for people living with HIV / AIDS and associated infections in resource-poor countries.

(2) **ESTHER** (Together for a Therapeutic Hospital Solidarity Network) today contributes to the overall care of People Living With HIV/AIDS (PLWHA) in 19 African countries, also in South East Asia, providing scientific, technical and financial support to partner countries. It comprises a network of more than fifty French hospitals involved in partnership with Southern counterparts and a hundred partner organizations. By providing expertise and financial support, ESTHER aims to strengthen the capacity of stakeholders to facilitate support of PLWHA.

(3) The French Ministries of Health, Foreign and European Affairs, and Finance ensure the supervision of the agency, which enjoys the legal status of a Public Interest Group as defined in the French law. The Group also provides the secretariat of the European ESTHER Alliance that brings together a dozen countries. Finally, the Group works closely with various UN agencies, such as: WHO, UNAIDS, UNITAID and the Global Fund.

(4) **UNITAID** was established in 2006 and its mission is to contribute to the scale up of access to treatment for HIV/AIDS, malaria and tuberculosis by leveraging price reductions of quality medicines, diagnostics and related products, which are currently unaffordable or unavailable for low and middle-income countries. UNITAID concentrates funding support for projects, which can demonstrate an impact on the markets for medicines and diagnostics, either through a reduction in the cost of medicines and diagnostics, an improvement in availability of quality formulations and suppliers or an increase in timely delivery of the required products to low and middle-income countries. UNITAID aims to support national and international efforts and complements the role of existing international institutions. UNITAID projects are implemented through partner organizations (the Implementers) that provide treatments, diagnostics and related products to beneficiary countries in three disease areas, HIV/AIDS, TB and malaria. One of the key challenges that UNITAID faces is making sure that the products it supports reach people in need.

(5) In 2007, ESTHER and UNITAID explored synergies to find common grounds for partnership that culminated in the signature of a MoU on December 15th, 2010. This original partnership, developed out of a stakeholder alignment, called “ESTHERAID”, brings UNITAID together with the French governmental aid agency ESTHER, for the first programme of its type in West Africa, to trace and ensure delivery of health products all the way from central medical stores to local clinics down to the patients themselves.

(6) ESTHERAID provides technical support to improve the supply chain management of UNITAID-supported health products in Benin, Burkina Faso, Cameroun, Central African Republic and Mali over a period of three years (2011- 2013).

(7) UNITAID funds either paediatric or second-line HIV treatments in all these countries and

ESTHERAID works with Ministries of health to ensure their correct use at treatment centres for people living with HIV through a tailored and targeted action plan specific to each country. It also works to optimize the quality of diagnosis, treatment and monitoring of patients. Each country response is customised and ESTHERAID intends to double the number of patients in need of paediatric and second-line ARV that will be supplied in each country it operates. The total available budget for this operation is 14,229,362 USD to finance Technical Assistance, Trainings, technical workshops for adopting standards, methodologies, tools or clarifying the roles and responsibilities of in- country stakeholders for, in particular, management of paediatric and 2nd line ARVs management.

(8) Another previous project of UNITAID, the CHAI (the Clinton Health Access Initiative) Second-Line Project (from March 2007-December 2011) focused on procurement of second-line treatments in 27 specified low and middle-income countries, including those of the ESTHERAID interventions

(9) CHAI also carried out upstream and downstream activities such as: forecasting needs in collaboration with each beneficiary country; submitting countries' orders; planning for receipt, clearance, storage, and distribution of drugs; and confirming the delivery of drugs in order to trigger payment to suppliers.

(10) In addition to its procurement functions, CHAI was responsible for providing technical support to countries to ensure the effective ordering, receipt, and use of project drugs, which amounted to 1% of the available budget.

(11) Those activities included product quantification, national protocol review and guidance, coordination of the provision of necessary technical assistance and securing treatment to patients free of charge.

(12) One of the main challenges for CHAI has been ensuring transition to other funding sources and helping countries to pool their orders.

(13) While the CHAI project focused on the purchase and delivery of second-line ARVs, the EA project is building (i) healthcare capacity to use these commodities, (ii) countries' capacity for timely product registration, (iii) accurate forecasting, (iv) efficient in-country distribution, (v) proper inventory management (storage or a logistics management data system LMIS), and (vi) rational use of drugs, making both projects complementary.

(14) But by the time EA project activities really took off, by mid-2011, the CHAI project was already coming to an end[1].

1.2. Description of the project under review

(15) During the final quarter of 2008, a workshop was organised by ESTHER with HIV stakeholders of the five selected African countries to identify three key intervention areas for the ESTHERAID project, in line with each national priorities. This workshop confirmed the need for a project to enhance the health and pharmaceutical systems in those countries and the

[1] When the EA project started In Benin , after the CHAI project was winded down.

motivation to participate in a joint multinational request submitted to UNITAID by ESTHER in 2008.

(16) ESTHER submitted to UNITAID the project proposals for the five countries. Mali, Benin, Burkina Faso, Cameroon, and CAR were selected to receive support from this programme for a period of three years beginning in the first quarter of 2009.

(17) UNITAID wished to develop a specific country-by-country plan as part of Phase 1 of ESTHERAID in the course of 2009. Phase 1 was conducted in 5 francophone African countries, selected on 5 criteria[2.]. They were already receiving ESTHER support in active partnerships between hospital teams from North and South; and four of them (except Mali) were evaluated in 2008 by UNICEF/WHO/ESTHER, so that recent data on their PSM situation (Pharmaceutical Procurement and Supply Management) was available.

(18) The overall objective of Phase 1 was to conduct a comprehensive evaluation of the fight against HIV and the actions performed with national partners in order to identify priority requirements with the view to updating operation proposals for the ESTHERAID Project. In accordance with the terms of reference of Phase 1, the adopted approach consisted, based on an updated report of the situation, in analysing the bottlenecks limiting access to the treatment and care of people living with HIV/AIDS (PLWHA); and to carry out an evaluation of factors influencing the availability and rational use of ARVs, especially paediatric and second-line ARVs, in the specific context of Burkina Faso.

(19) Phase 1 took place in Benin from October 13th to 30th, 2009. In Mali the evaluation mission took place between 8 and 20 November 2009. The evaluation mission for Phase 1 of the project in Burkina Faso was conducted between 8th and 19th February 2010 by a team of three consultants supported by two ESTHER coordinators in Burkina Faso.

(20) In the CAR the assessment mission took place from 25 February to 5 March 2010.

(21) Finally, in Cameroon the assessment mission took place from 5 to 15 April 2010.

(22) After conclusion of this Phase 1, on December 2010, a MoU was agreed and signed between the World Health Organization acting in support of UNITAID ('WHO/UNIT AID' Geneva) and 'Ensemble pour une Solidarité Thérapeutique Hospitalière en Réseau' (ESTHER, Paris, France).

(23) The country budgets and country operational plans were defined and established. But the signing of the numerous partnership agreements, which were not foreseen in the initial schedule of activities and work plan, caused delays3.

(24) The project under review, ESTHERAID Phase 2, focuses on building healthcare capacity to use the commodities as provided in the CHAI 2nd line ARV project, with:

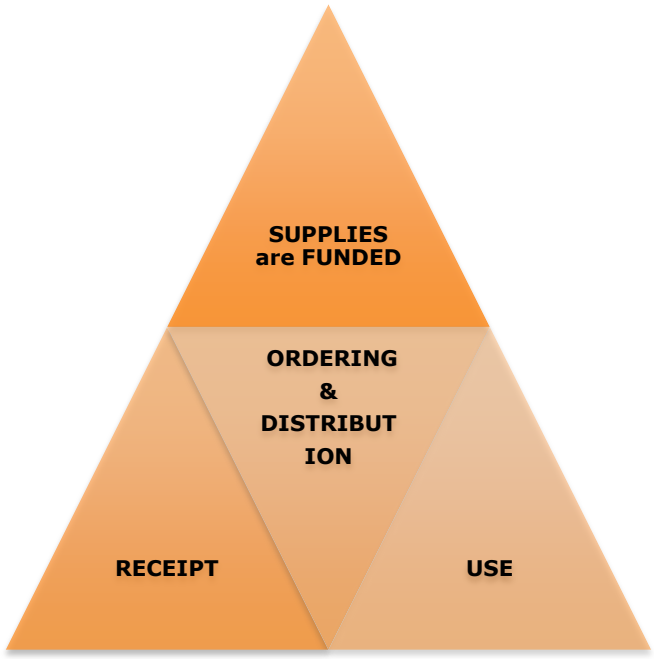
- Better forecasting of needs;
- Efficient in-country distribution;
- Proper inventory management;

[2] Criteria for county selection include, African, francophone, low income, weak supply system, previous Esther implantation.

[3] one year delay in Cameroon

- Rational use of drugs; and
- Capacity development in those areas

(25) **Diagram**: The following diagramme highlights that while ESTHERAID is contributing at all the levels identified above, it remains dependant on the national purchase of supplies and/or the funding requested for it.



1.3. Objectives of mid-term evaluation

(26) The **objective of the present Mid-Term Review** (MTR) is to assess the progress made towards the final objectives of UNITAID support to ESTHER for ESTHERAID, and the likelihood of the project achieving the objectives that were initially set. ESTHERAID provides support to 5 Francophone West African countries for supply chain management of medicines and tests for HIV/AIDS in children and 2nd line patients.

(27) The review will include recommendations on how project management can be improved to help achieve objectives more effectively and efficiently.

(28) In addition, the MTR provides recommendations on how to improve the effectiveness and efficiency of project management, including partner reporting on project activities and financial management. A section of the recommendations is to be implemented within the remaining life span of the project.

(29) The recommendations take into consideration how ESTHER could continue to support and strengthen supply chain management in the countries where it is now working and what may be required in the short term to support the project. Of particular interest is the connection between the availability of quality paediatric and 2nd line ARVs and UNITAID funding for these medicines.

(30) In addition, recommendations are made on how to mitigate stock outs of key medicines and tests.

2. KEY FINDINGS

2.1. Project progress to date

(31) This chapter has been structured along the questions of the evaluation matrix. This external, independent mid-term review (MTR) is structured according to the 'Organisation for Economic Co- operation and Development' (OECD) evaluation criteria of Relevance, Effectiveness, Efficiency and Impact, and in addition project-specific implementation issues and reporting arrangements are assessed. A SWOT analysis was performed and recommendations were issued, which are included in this report. The evaluation of achievements is based on the project-specific Monitoring and Evaluation (M&E) logical framework indicators as used by the ESTHERAID project management.

Criteria	Questions
Relevance	1. Are the activities and expected outputs of the project consistent with the objectives and expected outcomes as described in the project plan? 2. Has phase 1 provided relevant contribution to phase 2 and correctly established the strategic priorities? 3. Is the tandem UNITAID- ESTHER relevant and why?
Effectiveness	4. To what extent are the objectives of the project achieved so far? 5. To what extent are they likely to be achieved within the planned timeframe? 6. What are the main factors influencing the achievement or non-achievement of the objectives?
Efficiency	7. Are the project partners working closely with the relevant national authorities in the project's beneficiary countries? 8. Has the training of the stakeholders on the different levels improved the capacity in their daily work to benefit the final beneficiary in levels of available supplies, availability of treatment and quality of prescriptions? 9. To what extend are UNITAID supplies still available in the countries?
Impact	10. Can the partner organizations attribute improvements in supply chain management and appropriate prescriptions to UNITAID funding?
Sustainability	11. Are the processes/systems introduced by ESTHERAID sustainable? 12. Are the transition/exit strategies in place; are sources of funding identified, available and used?

2.1.1. Relevance

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

Findings

(32) The three-year ESTHERAID project in Benin, Burkina Faso, Central Africa, Cameroon and Mali aims to extend the number of patients receiving paediatric and/or second-line ARVs in about 10 [6-13] selected Treatment Care Centres (TCC) per country by strengthening the supply chain and the health system capacity. The ESTHERAID project's three main objectives in the respective countries are:

- **Objective 1**. Improve the performance of the ARVs supply management system from the central medical store to the selected peripheral delivery endpoints, ARV include 2nd line ARV for adults in 4 countries not including CAR, and paediatric ARV in 4 countries not including Burkina;
- **Objective 2**. Optimize the HIV care offer for an increased and rational ARVs consumption in selected Treatment Care Centres (TCC); and
- **Objective 3**. Improve the data systems to track, record and compile ARVs stock/consumption data as well as patients' clinical data.

(33) The activities in the five countries are in line and consistent with the three set objectives.

(34) In the Evaluation and Programming documents for Phase 2, for each of the countries, ESTHERAID has developed specific activities and required outputs to reach those objectives. All are set down in elaborated country specific and country owned logical framework matrices, which will further be explained under the Chapter on implementation issues.

(35) UNITAID selects projects that are committed to influencing UNITAID's niches for medicines, diagnostics and related commodities and that are expected have a positive impact on the market. In this aspect the ESTHERAID project is atypical. It doesn't impact market prices or market availability, but ensures better forecasting, quantification and use of those products. Nevertheless, additional to the programme objectives, UNITAID has requested ESTHERAID to contribute to the countries' transition plans, which includes identifying tracks to ensure future funding, and securing procurement (see Chapter 2.1.5), as well as participating in coordination mechanisms for Procurement and Supply Management (PSM) in West and Central Africa.

2. Has phase 1 provided relevant contribution to phase 2 and correctly established the strategic priorities?

Findings

(36) Phase 2, the present project, is based on the preparatory work done under Phase 1 in 2009, which focused on identifying suitable partners and main bottlenecks (key issues, problem analysis)

(37) There was a time gap between the identification (Phase 1) and the implementation (Phase 2). During this period, workshops were held to ensure ownership and acceptation of the programme by the five partnering countries, and, at varying pace, bring all 5 to signing MoUs with the programme (see previous Chapter: Description of the Project).

(38) Between initial design in 2009 and early 2011, in the 5 countries, reality changed, together with some of the stakeholders, and most notably the Global Fund and its contribution mechanism; at the same time, the CHAI project for the purchase and delivery of second-line ARVs, funded by UNITAID was winding up. As a result the contextual analysis (bottlenecks, constraints and priorities) needed an update.

(39) In April 2011, the original proposal was reviewed together with the annual operational plan and budget while redefining the terms of implementation.

(40) The collaborating partners meanwhile also expanded and presently there are 139 participating partners in the EA programme including Central medical stores, main hospitals, treatment centres and the Ministry of Health (MoH) of the 5 countries.

(41) Comparative summary of the timelines in the five countries:

- In Mali, the identification phase for the ESTHERAID project took place from 8 to 20 November 2009. National workshops took place in May 2010, to align the interests of the Ministry of Health and the other stakeholders, like hospitals, central store, treatment sites and associations. The Government of Mali approved the Proposal in early June 2010 that constituted the base of the Programming Document for Mali (October 2010).
- In Benin, the program has been launched on January 20th, 2011. The country manager took office in February-March 2011.
- The same year the program was launched February 15th in Burkina Faso, and the activities started in April.
- In Cameroun, the ESTHERAID project was launched on April 12th, 2011, while the MoU was signed in July same year. In November 2011, an agreement was signed with the fiduciary company, the delay due to the presidential elections.
- In CAR, the country manager took office mid February 2011. The program was launched June 17th 2011. MoH validated the re-programming in October 2011.

3. Is the tandem UNITAID - ESTHER relevant and why?

Findings

(42) Mandate and business models of UNITAID and ESTHER are fundamentally different and only converge on the objective to contribute to scaling up the access to treatment for HIV/AIDS. One of the main challenges for UNITAID is to ensure that the products funded through its programs reach the point of care to patients who need them. Both UNITAID and ESTHER, through their unique partnership and stakeholder alignment, target monitoring and delivery of health care products from central pharmacies to peripheral treatment centres and finally to the patients themselves. Access is used in its widest definition of quality of products, quality of their prescription, and their delivery at the lowest price.

(43) Three levels are considered important in the functioning of the supply chain and also in the exit/transition strategy of UNITAID: effective ordering, receiving and use of medicines.

(44) The CHAI Second-Line Project acted on a more upstream level and carried out activities such as: forecasting needs in collaboration with each beneficiary country; submitting countries' orders; planning for receipt, clearance, storage, and distribution of drugs (downstream); and confirming the delivery of drugs in order to trigger payment to suppliers.

(45) It can be stated that the ESTHERAID project fits within the logic of intervention of UNITAID. The fact that the ESTHERAID project builds the capacity at different levels (laboratory staff, medical staff, pharmacists and central store personnel) will allow for patients to have easier access to quality health products and services and will also increase and ensure the availability in sufficient quantities and timely delivery of optimized treatments to patients. According to ESTHER there does not exist similar projects covering the strengthening of the entire supply chain of health products from diagnosis to treatment and prevention of HIV/AIDS.

(46) UNITAID financing such programme as ESTHERAID is relevant as it leverages and complements other projects and programs financed by UNITAID, extend the outreach, and increase UNITAID impact on relevant markets and ultimately on public health.

(47) Quantification and demand forecasting is difficult for these countries, yet essential to keep the prices low. It is known that predictability of orders and long-term agreements keep the marginal costs lower, while emergency orders inflate prices of supplies. ESTHERAID is contributing strongly to accurate forecasting and efficient management of the respective countries demand and quantification; it is therefore relevant and complementary to UNITAID objective.

(48) There is also an ethical aspect, requiring that public money should translate into public health. And this is triggered by ESTHERAID contribution to avoid waste and promote efficient use of supplies, building up quality assurance and human resource capacity for the release of products[4].

[4] Besides the ethical use of supplies, Tons of supplies and ARVs have been lost or would have been lost in ports and airports, if not for CHAI and Estheraid intervention.

2.1.2. Effectiveness

4. To what extent are the objectives of the project achieved so far?

Findings

(49) The following Table 2 shows the operational and financial progress as available by the middle of February 2013: the programme progress after one year and after 23 months (to be updated soon for the Second year reporting).

(50) The first 2 columns show the outputs realized in that period. They are based on the activities outputs of each country logical framework. The units are not comparable: Some correspond to the mobilization of technical assistance for two months while others refer to a one-day workshop with two partners.

Table 2: Operational and financial progress

Country	M24 Means realized %	M12 Means realized %	M24 Overall Expenditure %	*Children under paediatric ARV*** 2012	Target	*Adults under 2nd line ARV* ** 2012	Target	Compare progress since 2011 *Children/Adults*
Benin	50	26	40	787	1078	449	846	542/423
Burkina	55	19	45	NA	NA	298	340	/237
Cameroon	25	2	30	1691	2836	2924	2402	1101/1452
Mali	30	0 *	13	1502	2346	1869	3656	1369/1869
CAR	30	5	20	536	1175	NA	NA	406 /

* *Budget execution: 2%*

** *Active file, outpatients: number of patients followed up at least every 3 months in each treatment site.*

Comments:

Interruption of 2nd line ART initiation during the 2nd semester 2012 because of stock-out risk and to secure current ART cohort

Audit by GF in September 2012 helped to clean up all the lost to follow-up from the active file numbers

NA : Not Applicable

Achievement of project objectives

(51) To comply with the first Objective, initially national procurement and supply management committees and other coordination platforms were created in Benin, Burkina Faso and Cameroon. This was necessary because the main cause of stock outs are: i) lack of funds, ii) bad quantification and iii) inaccurate forecasting, mostly due to lack of alignment, coordination and communication between the Financial and Technical Partners, donors and stakeholders.

(52) One of the objectives of the project ESTHERAID is to reduce as far as possible, the issue of stock-outs. To this end, a cluster of programme activities is dedicated to this topic at the central level. General Directorates[5] are a central partner in the ESTHERAID project and at this ministerial level capacity can be created to pilot the national monitoring Committees of management of ARVs and other supplies to respond to the HIV epidemic. Indeed, committees are created to meet the challenge of securing the supply of pharmaceutical and sensitive products. National and district committees are platforms of communication that can coordinate activities related to the sound management of ARVs and other supplies, all the way from needs assessment to use in the field.

(53) They are a key element to reinforce the HIV pharmaceuticals management, and thus procurement and supply chains from the Central Medical Stores to the Treatment and Care Centres included in the project. The roles of these committees, established with full support and logistics of ESTHERAID includes:

- Coordinate the development and monitoring of the implementation of plans relating to the procurement of ARV stocks and other inputs in the response to the HIV epidemic by the different actors involved;
- Ensure the establishment and effective functioning of a coordinated information system for the management of ARVs and other inputs in the response against HIV;
- Ensure rational use of ARVs and other inputs in the response to the HIV epidemic according to the standards and protocols in the country;
- Monitor the quality and cost of ARVs and other inputs in the response to the HIV epidemic;
- Support monitoring of adverse events and early warning signals.

(54) The roles of these committees are closely aligned with objectives and system re-enforcement of many UNITAID' funded programmes.

(55) Although UNITAID relies more on private competition and free markets, the problem here is that the programme countries, as most countries in Central and West Africa, are not equipped and cannot assure transparent sample control and quality check of imported drugs. Quality control is at best limited to products arriving in the Central Store, and generally relies on products of known and trusted origin.

(56) The boosting of national platforms and committees for supply management are one of the lessons learned from this programme and proves essential to implement in all countries where UNITAID is involved in increasing access to 2nd line and paediatric ARV medicines. ESTHER and ESTHERAID experience in this respect needs to be capitalised upon especially in French speaking African countries.

(57) The 5 ESTHERAID programme countries are also interlinked and work together under the

[5] As there is the General Directorate of Pharmacy, Medicines and Laboratories (DGPML) in Burkina Faso

umbrella of ACAME (Association of African Central Medical Stores for essential Drugs)[6.]

(58) ESTHERAID updated pharmaceutical standards and procedures, and quality assurance procedures. The impact of those pharmaceutical activities conducted at central level is essential for structural health systems but results are long-term. Because it has no short-term impact to allow patients to benefit from ARV paediatric and 2nd line quality, it is not considered as priority in the strategic work-plan for the remaining programme time.

(59) At the beginning of the project each regional distribution centre was working independently and had no connection with the central distribution centre[7.] After ESTHER intervention, now the district stores are in contact with the central store and in some countries like in Burkina Faso and Cameroon, this mechanism has been institutionalised through political decrees as described in Chapter 12 below.

(60) The programme initiated the evaluation of the existing computerized ARV stock management and dispensing tools. To improve the database, software (Medistock[8]) is currently under configuration in Benin. When the specificities are further defined, it is planned that this database would be deployed in Benin, Burkina Faso and Cameroon[9].

(61) For clinical monitoring of PLWHA, the programme installed a software in most of the treatment and care centres covered by the project in Benin, Mali, Burkina Faso and in Cameroon (ESOPE for adults, and the paediatric version will be installed in the Treatment and Counselling centres with a large paediatric cohort).

Training programmes

(62) Training is crosscutting and contributes to ***all three objectives*** of ESTHERAID, including the transition and sustainability of the project.

(63) Comprehensive training activities include exchange programmes, internships, and supervision missions to the peripheral centres with coaching, and tutoring. North-South twinning activities

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[6] ACAME could be beside Opals (The Pan-African Organization against AIDS) one of the preferential partners in the context of the plethora of partners' reduction in the restructuration of Estheraid programme during the no-cost extension. ACAME includes twenty members whose common goal is to improve access to essential medicines for poor people in Africa. For reasons of local capacity development, rationalization of distribution circuits, economies of scale and also sustainability, ACAME supports the optimal use of national Purchase Centres. This concerns both the supply of drugs and supplies, as support of programs against priority diseases (HIV AIDS, malaria, tuberculosis). ACAME strives to contribute improving or enhancing the performance of these national Purchase Centres.

[7] In CAR some coordination meetings took place, but the CAR-ESTHERAID project is specific and restricted to paediatric decentralisation. On the other hand the strategic priority of Burkina Faso focuses on 2nd-line ARV for adults.

8 The software MEDISTOCK®, was conceived by URC-PISAF with the financing of the President's Malaria Initiative (PMI) and designed for the management of pharmaceuticals to treat malaria. The specifications are being drafted with the national authorities, the beneficiaries and international consultants in order to tailor the software for ARV management and dispensing, taking into account the needs of the stock managers.

[9] Difficulties from the start to identify and adapt/develop a computerized management tool for dispensing of ARVs, move ESTHERAID to reorient these activities towards capacity building in the use of improved paper based management tools and simple excel file.

are also a key element in strengthening capacity of human resources,

(64) Training covers all levels of the full chain that links diagnosis, prescription, forecasting, treatment, to distribution and dispensing of drugs, and includes monitoring (data collection, early signals). The training of prescribers ensures good prescribing practices for diagnosis, paediatric ARVs and 2nd line.

(65) To strengthen the skills of caregivers (Objective 2), an Inter University course and Diploma (IUD) is provided to doctors and nurses on Comprehensive Care of PLWHA.

(66) The training also improved the accuracy of the data (monitoring) regarding treatment adherence of patients. The medical care of patients improved through fine-tuning the choice of ARVs (including FDCs) with training on monitoring adverse effects of ARVs, and on how to manage/mitigate therapeutic failures.

(67) Practice has improved through exchange of best practices during visits to other treatment sites, and internship in tutoring hospitals.

(68) Training in psychosocial support completes the therapeutic cycle with training in therapeutic patient education (ETP).

(69) Meanwhile training in 'formative evaluation' ensures ownership and further management of the programme.

(70) In compliance with Objective 3[10], the Inter-University Diploma course (IUD) on 'management of stock and pharmaceutical supplies' contributes strongly to Objective 1, and since end of 2012 there is a notable improvement, in particular as regards the supply of reagents for HIV testing, and availability of other supplies, reinforced and evidenced by regular monitoring of the activities[11]. In Benin the conception and implementation is in place for the software Medistock[12].

(71) The Introduction and training to use the patient software ESOPE[13] and its roll out with a training of trainers contribute to objective 3.

(72) *Table 7* gives a comprehensive idea of the trainings conducted for the staff in Burkina Faso.

(73) *Table 8* is an overview of the trainings in Cameroon[14].

[10] Improve the data systems to track, record and compile ARVs stock/consumption data as well as patients' clinical data.

[11] According to respondents in Mali, the early diagnosis for infants born to mothers with HIV has improved drastically.

[12] Initially planned for roll out in Burkina and Cameroon, programme delay necessitates simpler tools like improved paper based data and excel.

[13] In 2011 the software ESOPE was installed in all the TCC in Burkina and the DRS users and supervisors received training from national and international experts. In order to install the software, five computers were purchased. Since May 2012, a person in charge of monitoring and evaluation is also responsible for the updating of the databases, the quality control and the collection of indicators.

[14] To have an idea of the updated and comprehensive training plan for the 5 countries, the reader can refer to the 'Copie de Planification et suivi des activités formation et expertise 5 pays', in ANNEX 6.7.

Training Pharmacists

(74) Pharmacists of Treatment and Care Centres and of central stores in the five countries received training in IUD-stock management and pharmaceutical supplies. They also received assistance for the preparation/upgrade and/or implementation of Quality Assurance Manuals in the countries where the manual did not exist or was obsolete and needed upgrading.

(75) The impact of pharmaceutical activities conducted at central level for structuring health systems (updated pharmaceutical standards and procedures, updating quality assurance procedures) has an overall effect on the long term and but does not always have a measurable impact in the short term, to allow patients to benefit from ARV paediatric and 2nd line quality treatments. It was a main activity up to date but because of the programme coming short of time, it is at risk to not be kept as priority for the revised work plan.

(76) Monitoring of adverse effects of ARVs is included in the training programme, together with comprehensive care of PLWHA, and Management of treatment failure among PLWHA.

(77) Next paragraph on equipment gives a short overview of hardware bought on ESTHERAID budget to facilitate and substantiate the gains of training and reinforcement of supply, diagnostic and treatment systems.

Conclusion

(78) The training programmes, presented here, reinforced the roll out of databases and their application in decentralised peripheral Treatment Centres, paired with a Trainer of trainers programme to facilitate the rollout, to cope with human resource movements, to prepare exit and to ensure sustainability. Those activities may be underestimated in other programmes but provide a strong added value and are key elements of the ESTHERAID programme, allowing attainment of the objectives and increasing expected impact of UNITAID to ensure proper supply, dispensing and ethical use of ARVs and UNITAID funds.

(79) More patients treated with quality 2nd line medicines

(80) More patients started on treatment with quality-assured child-adapted formulations, including fixed-drug combinations (FDC).

Table 3: List of trainings in Burkina Faso

N°	Date	Training	Trainees	Numb
1	6 to 11 Feb.	Training of Trainers at the tutor hospital HDJ Bobo in ETP	Counsellors psychosocial	11
2	06 Feb. to 3 Mars	IUD Management in pharmaceutical procurement	Pharmacists	7
3	18 to 24 Feb.	Management of therapeutic failures with PLWHA	MDs and Pharmacists	18
4	02 Apr to 22 Dec	Training in coding of databases for ESOPE	MDs, and paramedics	100
5	16 to 21 April	Training of Trainers in psychosocial accompaniment en helping relation	Pluri-disciplin. teams	15
6	March and Nov	Internships in pharmaco-vigilance centres in France	Pharmacists	4
7	27 Mai to 2 June	Training of CPS in psychosocial support and helping relation	Pluri-disciplin. teams	25
8	29 Mai to 2 June	IUD in holistic care of PLWHA	3 MDs and 1 paramedic	4
9	09 June to 6 July	Training of the care teams in the sites of ESTHERAID in ETP (helping relation)	Paramedics	57
10	30 July to 3 Aug.	Training in protocol and data processing of pharmaco-vigilance	Pharmacists	8
11	29 to 31 Aug.	Training on good practice in drug distribution	Pharmacists; Preparators	28
12	08 to 12 Oct.	Training leading designers on the development of educational tools for education of patients living with HIV in Francophone Africa.	Paramedics	3
13	30 to 31 Oct.	Training on the system of collection, storage and transport of samples to achieve viral load to HDJ	Biologists	21
14	05 to 10 Nov	Training psychologists to psychosocial support and supervision	Pluri-disciplin. teams	15
15	10 to 14 Dec	Training in the data analysis STATA	MD	1
16	17 to 18 Dec	Training biologists on three Guides of Good Practice of Laboratory Analyses	Biologists	26
17	19 to 21 Dec	Training of biologists in management of laboratory supplies	Biologists	26
TOTAL		**TRAINED**		**128**

Table 4: List of trainings in Cameroon

Training	Trainees	Number
IUD pharmaceutical management	Pharmacists	3
IUD Retro-virology	Biologists	3
Management of paediatric ARV and ARV 2nd line	Staff	30
Post-exposure chemoprophylaxis (PECP)	Medical and paramedics	133
Develop educational tools for ETP (therapeutic patient education)	Chief designers	2
Coordination of pharmaceutical supplies	Staff of regional units	100
TOTAL		**271**

The Equipment provided on ESTERAID funds, sustains the advances made in management processes (database, diagnosis, and supply management)

(81) ***In Burkina Faso***:

- Semi-automatic extractor for viral load in the reference hospital of Bobo;
- At peripheral sites, freezer for samples and centrifuge.

In the *CAR*:

- Computers for the sites' collection of patient data (ESOPE);
- Rehabilitation of the Day Hospital of the Paediatric Complex;
- Purchase of storage cabinets for ARVs in pharmacies.

(82) ***In Benin***:

- Rehabilitation of CNHU (upgrade laboratory);
- Equipment and rehabilitation of the dispensing space;
- Computers for patient and medication data collection; and
- Equipment for 10 sites: air conditioners, pallets, shelves, and cabinets.

(83) ***In Mali and Cameroon***: no equipment or rehabilitation was purchased under ESTHERAID budget.

5. To what extent are the objectives of the project likely to be achieved within the planned timeframe?

(84) As Table 2 shows (progress on means consumption /activities up to month 24), Benin and Burkina have complied with slightly over half of their activities, Cameroon a quarter, Mali and the programme in the Central African Republic have attained a third of the programme expected outputs.

(85) Overall Burkina Faso has made the most progress and started consolidation of the outputs. Concerning the follow up of patients, the patients put on 2nd line treatment are close to reach the target (programme OVI as set in the LFM) in Burkina Faso, are halfway the target for adults treated in Benin and Mali, and are over the target in Cameroon. Paediatric ARV treatments are over half target in Cameroon and Benin, and largely over half target in Mali.

(86) While some countries are still in the stage of structuring activities, all countries need more time to consolidate the achievements and secure norms and procedures, to ensure their sustainability, as part of the transition strategy. Norms and standards were introduced in Burkina, Cameroon and the CAR.

(87) Mali and Burkina Faso need an extension of a minimum of 9 months to help complete the intervention, and to implement all planned activities.

(88) Benin and Cameroon will need an additional year to complete the intervention, but there is a threat that without supplies, the main results will be difficult to achieve even with an extension. Without reagents for viral load, there is no passage to second line treatment, especially when people were trained to adapt treatment based on the viral load. The CAR could even need up to 18 months extension to catch up on the full intervention.

(89) Especially in Mali, CAR and Cameroon, due to incurred delays and to time constraints the programme management reset the work plans for the third and the extension year by prioritization and streamlining of activities, also discussed under chapter 2.3.4 on no-cost extension.

(90) For the countries with political instability the new strategy for the remaining period is to set up a remote support to the national human resources and organising workshops bringing together the medical staff of supported sites with the experts in neighbouring countries, including French (twinning) partners.

(91) For each country, activities were reviewed for the remaining period and prioritized according to their impact on access to care. Since the beginning of the programme, these activities mainly concerned the capacity at central level (evaluation, updating manuals and procedures, structuring of the health system). In Benin for instance, 2013 will mark the implementation of the first phase and will centre on helping strengthen national capacities at the supported sites. For 2014, planned activities are focussed on consolidation of the structural gains and support to the supervision activities implemented by national institutions.

(92) In this revised programming, in addition to strengthening the supervision and training, some activities have been substantially modified from the initial programming. Where needed, technical expertise will be strengthened, local staff essential for the programme will receive

extra trainings and scholarships, and allowances will be paid for key posts.

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

Stock-outs

(93) Without smooth and regular supply and availability of drugs and reagents for diagnosis (objective 1), it is impossible to reach objective 2, which indicator is to increase the intake of patients on 2nd line ART and paediatric ART by 50% from the baseline.

(94) Supply management, forecasting and efficient distribution have proven to be challenges in 2011.

(95) In the CAR, access to ART was mainly affected by the interruption of funds by the GF, negatively influencing the arrival of laboratory supplies and paediatric drugs in the first semester of 2011.

(96) All countries experienced at some point supply shortage or stock outs of antiretroviral and diagnostics drugs. In Burkina Faso, the situation regarding diagnostics was drastic all year long mainly due to bad forecasting and quantification.

(97) In Benin the supply was erratic for 2 years, on all relevant drugs (including 1st line treatment) and reagents, with additionally the reference laboratory not being functional for a period, and therapeutic failures not being identified.

(98) Cameroon narrowly escaped a stock-out thanks to CHAI, but the treatment of OI was affected.

(99) Mali was severely affected by the interruption of the GF signature till September 2012 and the coup in March of that year and resulting instability.

(100) One of the bottlenecks with testing machines is that they can only use the testing products corresponding to that particular equipment, which limits alternative strategies in case of stock-out of a particular product.

(101) The remedies to these problems remain at many levels. As explained in Chapter 2.1.2, the stock outs are caused by, i) lack of funds, ii) bad quantification and iii) inaccurate forecasting, mostly due to lack of alignment, coordination and communication between the Financial and Technical Partners, donors and stakeholders. ESTHERAID interventions deal with level ii) and iii)[15].

Dilution of the efforts and its translation in the extension year

(102) In spite of the most positive experiences on training and monitoring, respondents in Benin commented that comprehensive coverage happens at the cost of in-depth improvement of each of the treatment sites. As mentioned before, there are over 139 partners active within the five African countries.

[15] See also the options discussed under section 2.1.5 on CPP and JURTA.

(103) On the other hand, much depends on the stewardship of the country. In Benin the MoH stipulated that 80% of the treatment and care centres must have access to decentralised care and made the biological follow-up part of the minimal package, and that includes CD4 count[16].

(104) In January 2013 the teams of ESTHERAID managers developed work plans where pharmacy activities refocus onto sites rather than continue central support, because the impact is greater for improving access to treatment for patients (strengthen management skills and distribution systems to treatment sites, needs assessment processes, and in dispensing sites, coordination and communication mechanisms between the different sites and the central level). Pharmaceutical activities conducted at central level for structuring health systems (updated pharmaceutical standards and procedures, updating quality assurance procedures) so far have an overall effect on the long term but do not necessarily produce a visible impact in the short term to allow patients to benefit from ARV paediatric and 2nd line quality treatments. It was a main and very useful activity up to now, but because of the programme running out of time it will not be kept as a priority for the revised work plan.

(105) Similarly the development and testing of an ARV management and dispensing tool for treatment sites as presently running in Benin, is not commensurate with the remaining lifetime of this programme. Technical difficulties surfaced in training managers in computer networking and maintenance of computers. It is proposed to shift these activities to strengthening skills in the use of paper-based tools or simple excel files for the other project countries, a mitigation strategy that still faces real problems.

Human resources

(106) The training activities cannot escape inherent constraints. In most of the ESTHERAID project countries, the trained staff is been shuffled around and to central level, by promotion, by admission to specialization or to the private sector, and all this entails needs for retraining. There is also a problem with the qualification of staff responsible for the management and especially the dispensing of ARVs[17].

(107) In Benin where there is already shortage of human resources18, and a fortiori of qualified human resources for the Health sector, the human resources assigned to the Global Fund, were shifted from the GF system to the public sector, but many then left. In the CAR, the elections caused for the project to have to work with new people, which entailed delays.

(108) ESTHERAID made a strong plea to the national authorities including the Ministry of Health towards strengthening human resources. This advocacy has resulted in the assignment of a

[16] The challenge is that this requires maintenance and indeed the Benin report mentioned that a CD4 count was defective.

[17] In Cameroon a lot of staff was just trained on the job, for instance pharmacy clerks or even pharmacists who have no expertise in logistics management.

[18] The challenge can be measured in Benin at the division of drug and laboratory products NACP (PNLS): the staff is limited to a pharmacist, a nurse and a manager. There is no specialist for the quantification and forecasting of supplies, and no statistician or database manager within the team, while mandate includes quantification of ARVs that are complex.

number of staff. Advocacy continues.

(109) To deal with identified movement of personnel, the competence of the replacement is strengthened when needed[19]. Three approaches are used to deal with this issue[20]:

- A plea is made to the policy makers to limit staff movement at ESTHERAID sites;
- The training of national trainers in various disciplines ensures regular updating;
- Refresher training is conducted.

(110) In general and in spite of the quality of the initial trainings, continuous and appropriate capacity improvements are necessary for all staff, be it doctors, pharmacists, nurses, technologists, biomedical, or psychosocial counsellors.

(111) Therefore the training of trainers as implemented by ESTHERAID for the ESOPE database and for the Therapeutic Patient Education (ETP) responds to a real need. The strategy adopted by the project is adequate to cope sustainably with staff turnover.

(112) All trainings contribute qualitatively to strengthening the skills of those involved in the case management at the ESTHERAID project sites.

Insecurity and political instability

(113) Besides instability in Mali (March 2012 and the third trimester of 2012) and CAR, the other causes of programme delay are related to management issues and will be discussed under Chapter 2.3.4.

(114) More will be said on future interventions to deal with the remaining project-time and work plans, in order to reach the set objectives.

[19] This is the case in Mali but is also applied in the other programme countries.

[20] Applied in Burkina Faso and in the CAR.

2.1.3. Efficiency

7. Are the project partners working closely with the relevant national authorities in the project's beneficiary countries?

Findings

Ownership

(115) At the start of the programme in phase 1 and beginning of phase 2, workshops were organized to align the programme to countries' policies and priorities. Also training in formative evaluation tends to increase stewardship by the implementers.

(116) Beyond streamlining procurement, storage and distribution of drugs, the ESTHERAID programme also strengthens direct health systems. For that reason the stakeholders apply the funded training to improve their management and treatment of HIV/AIDS patients at both national and peripheral level.

(117) Initially national procurement and supply management committees and other coordination platforms were created in Benin, Burkina Faso and Cameroon (see 2.1.2 'Achievement of project objectives'). As explained in detail in chapter 2.1.2, the committees are key to reinforce the HIV pharmaceuticals management and supply chains from the Central Medical Stores to the Treatment and Care Centres included in the project.

- In Burkina Faso, management procedures for supplies were updated together with the national guidelines for procurement, and a methodology was developed with a monitoring tool for pharmaco-vigilance.
- In the CAR and Cameroon, work was conducted with the establishment of a national referential for pharmaceutical standards.

Participation

(118) As for all tools developed within the project, the validation is done with the national authorities, so that ultimately, these tools can be used at national level, be it paper folders for ESOPE, reference tools and contra-reference, specimen collection, measuring viral loads at the tutor hospital, and return results at peripheral sites, functional communication, or tools for helping communication (ETP). ESTHERAID has developed detailed participative mechanisms for all the processes it promotes.

Supervision

(119) In each country the steering committee of the ESTHERAID programme does the annual supervision with its partners.

(120) For project follow-up, ESTHERAID trained teaching hospital staff on formative assessment[21] and their teams perform quarterly supervisions at the treatment sites. An evaluation Matrix was designed for this purpose and takes into account the clinical, pharmacy, laboratory, the

[21] In Burkina, HDJ Bobo and in the CAR, in the Bangui Paediatric Complex (CPB).

therapeutic education of patients (ETP), and use for ESOPE. In Benin to date there is no supervision planned after training. Under the project plan ESTHERAID foresees supervision (not necessarily formative) in year 2, but delays postponed implementation to year 3 (2013).

(121) In Burkina Faso the International Technical Assistants (ITAs) supervise patient treatment education (ETP) and psychosocial support (APS), and psychosocial counsellors supervise the peripheral sites.

(122) There is also a semi-annual supervision of the supplies (delivered products) by the Management Committee[22].

(123) At the peripheral treatment sites, teams of the health sector programs against AIDS (PSSLS in BF, DGLS in CAR) perform semi-annual supervisions, in support of the regional health teams.

(124) But involving all the stakeholders is a continuous process, and, as demonstrated in the case of CAR, referring to the GF contribution of supplies for the routine screening of children, which was introduced at the voluntary screening only[23], coordination is necessary and can always be improved to avoid duplication in order to reach 50% increase of paediatric ARV treatment.

8. Has the training of the stakeholders on the different levels improved the capacity in their daily work to benefit the final beneficiary in levels of available supplies, availability of treatment and quality of prescriptions?

Findings

The usefulness of medical training

(125) As explained above, in the training section, case management of HIV/AIDS of the staff of the decentralised treatment centres, diagnostic capacity, and supply quantification and management has improved in many key areas including the management of daily operations, with an increased knowledge on principles and strategy of ART, and with the developed capacity to manage treatment failures, and trace defaulters.

(126) By training more doctors involved in the care of HIV/AIDS patients and Opportunistic Infections (OI), the provision of care is also better in terms of number of consultations issued. More patients can be seen and treated. The training in ESOPE at the treatment site proved to be so useful that if funds permit, scaling-up could be foreseen nationally in Benin and Burkina Faso and a sub-regional Seminar on ESOPE could be proposed for 2014, for exchange of experience, sharing lessons, and data analysis.

(127) Equally for the therapeutic education of patients (ETP), ESTHER management suggests that

[22] In Burkina piloted by the DGPML (DG for drugs and laboratory).

[23] Rapid tests were used to identify infected children of >18 months. These rapid tests are part of the stock available at the UCM GF and estimates for these tests were made at the time by considering only the adult population (phase 2 R7, VCT supplies). At the time, only DBS had been ordered for the diagnosis of children (UNICEF), but the population [2-15 years] that may be diagnosed with rapid tests were not included in the calculation needs.

remaining funds could be used for further scaling-up and dissemination of developed tools and training sites in other ESTHER sites of the 5 countries (beyond ESTHERAID sites).

(128) The quantity and types of trained staff have facilitated the decentralisation. In the CAR for instance there was a bottleneck to decentralisation by lack of trained staff. Other countries also improved quality of treatment and attendance. The programme managed by intensive training to have more experienced medical staff in screening and care, and in decentralized screening. As a result, the ARV treatment for children less than 24 months of age, besides the 2nd line treatment for adults, has drastically improved. The training led also to create and supplement other necessary staff like providing a psychologist on the site.

The usefulness of pharmaceutical training

(129) The Norms and Good distribution Practices have become institutional for pharmacies and laboratories under the ESTHERAID project. In the CAR for instance 'Norms and Practices'24 were obsolete before the ESTHERAID project start.

(130) Through training and improving systems, ESTHERAID has contributed to reducing disruptions of ARVs, in particular those attributable to inventory management. Other essential activities in the countries, at different stage of progress to move ahead towards achieving these objectives are:

- The development of normative documents and pharmaceutical guidelines.
- The development of manuals of good practice for storage and distribution of HIV supplies.
- The training of trainers and actors in tools for distribution.
- The training of prescribers and pharmacists in charge of quantifying the needs for rationalization of orders.

9. To what extend are UNITAID supplies still available in the countries?

(131) While the CHAI project focused on the purchase and delivery of second-line ARVs, ESTHERAID is building (i) healthcare capacity to use these commodities, (ii) countries' capacity for timely product registration, (iii) accurate forecasting, (iv) efficient in-country distribution, (v) proper inventory management (storage or a logistics management data system LMIS), and (vi) rational use of drugs, making both projects complementary, within a shared logic of intervention.

(132) But by the time ESTHERAID project activities really took off, like mid 2011, the CHAI project was winding down. This was very unfortunate because the main delays in achievements of the programme are attributable to recurrent stock-outs. Supply management, forecasting and efficient distribution have proven to be a main challenge throughout 2011. As explained before, all countries experienced at some point supply shortage or stock-outs of antiretroviral

[24] The Pharmaceutical Norms in the CAR hadn't been updated for 20 years.

and diagnostics drugs.

(133) On the other hand all the work done by ESTHERAID has improved the supply situation in all 5 countries, at least in the TCCs covered by the programme. The trigger for improvement is situated at different levels where ESTHERAID intervened[25.]

- As for structural and institutional support, ESTHERAID facilitated and participates at National Committees for monitoring and management of ARVs, with demonstrated contribution to better quantification and forecasting of supplies (see 2.1.2, Achievement of project objectives).
- At those committees, ESTHERAID is vocal in advocacy for transition between GF rounds, proposed solutions to remedy a couple of stalemates and advocates for secured funds.
- ESTHERAID has contributed to improve the legal background, with the development and gradual absorption of upgraded norms and rules for supply management.
- ESTHERAID worked intensively on database improvements both for patients and for supply management.
- ESTHERAID intervention can claim improvements of the rational use of ARVs and diagnostics.

[25] More details of structural and system improvements can be found under 2.1.5, Question 11, the chapter on Sustainability.

2.1.4. Impact

10. Can the partner organizations attribute improvements in supply chain management and appropriate prescriptions to UNITAID funding?

Findings

(134) Yes, in the pharmacies of the TCCs and in the Central Stores and distribution centres covered by the ESTHERAID programme, there is now evidence of proper distribution of drugs, improvement in the disruption of supplies, and increased availability of supplies at all project sites. As a result the management of all pharmaceutical products has improved with Indicators for quality in anti-TB, malaria, and HIV in particular[26.]

(135) The staff responsible for supply management has also been enabled to perform the monitoring and evaluation of suppliers.

(136) In all countries, the respondents of the review questionnaire confirmed that thanks to ESTHERAID they had strengthened skills for supply and stock management, for monitoring the quality of products, and for the organization of a good distribution system[27.]

(137) There is evidence of more efficient data collection and management through various collection tools, that in turn allow to evidence better supply chain management and more accurate prescribing practices. This improved quality of care and of better follow-up services result from training provided by ESTHERAID in collaboration with the Ministries and concerned departments for drugs and medicines and the fight against HIV/AIDS.

(138) The ESOPE computerized management with real-time capture saves valuable time, by better management of appointments, defaulter tracing, and reporting. In Burkina Faso and in Mali for instance, the ESOPE Software for HIV care has been developed in the peripheral sites, where it is now easier and more effective to perform regular data collection and monitoring of patients, and to retrieve the records of PLWHA. Patient records are easier to exploit. This led to the enhanced coverage and timeliness of HIV data, and as a consequence to a better and more rational use of ARVs.

(139) Due to training, exchange practises and twinning, the programme improved the clinical biological monitoring of ARV patients, through better prescribing practices, and better organisation of the services. The patients have now fixed appointments. The patient circuit is well defined. All actors are trained in care, and the quality care management has improved, leading to increased general patient satisfaction. The training that has been given, allows to

[26] In Burkina Faso, there was an update of the management procedures for supplies with updated national guidelines for procurement, and a methodology was developed with a monitoring tool for pharmaco-vigilance.

In the CAR, existing standards had not been updated for 20 years; work equivalent to that of Cameroon was conducted with the establishment of a national repository of pharmaceutical standards.

[27] As a respondent wrote in Benin: "ESTHERAID gave us hope with regard to the 2nd line molecules". Generally the availability of the viral load test to put patients on 2nd line has increased.

better deal with opportunistic infections (OI) and to provide adapted treatment protocols.

(140) The number of patients coming in and put on ARV treatment with regular monitoring has increased[28], and there are fewer defaulters, thanks to a computerized tracking system, facilitating the follow up of patients. In Burkina Faso for instance, ESTHERAID facilitated the identification of treatment failures and screening for hepatitis B in the active file.

(141) Staff is now empowered to interpret and as a consequence also acts on bottlenecks. Those positive results of the training delivered and better supply management practices are evidenced, when in Benin for instance the staff recognized that the delivery of reagents of poor quality needed to be remediated to avoid disrupted screening for several weeks and even months. TCC staff also initiated a request to put more attention to improve storage conditions at ARV treatment sites for PLWHA. And in Mali, the laboratory in Kai recognized and reported skewed results due to reagents of poor quality and defective cold chain. A last example of taking the situation in own hands and becoming proactive, came from Sikasso, where the staff requested support for a maintenance plan for their costly equipment.

(142) The staff at the Central store in Benin witnessed that "The consultation made at CAME for the implementation of the Quality Assurance Manual was a real opportunity; CAME has improved its documentation system for pharmaceutical acts." And "We note that stock-outs for paediatric ARV were practically zero in 2012."[29]

(143) Those examples prove that increased knowledge leads to increased ownership and management capacities of all levels of staff in the treatment and care centres and in the medical stores where the supplies can be more efficiently managed due to intensive training and upgrade of quality and numbers of human resources.

(144) Analysis of the respondents shows however that in the treatment centres of the five countries no distinction can be made between activities and resources originating from UNITAID or ESTHER.

[28] Clearly stated by the respondents in Burkina Faso and in the CAR.

[29] In Cameroon, ESTHERAID supports the strengthening of the distribution system and thus the availability of HIV supplies that are already in the pipeline.

2.1.5. Sustainability

11. Are the processes/systems introduced by ESTHERAID sustainable?

(145) ESTHERAID aims to improve access to treatment by promoting recommendations for optimized and rationalised treatment. This includes updating of national guidelines (which were not aligned with the WHO recommendations before the ESTHERAID project started) and the training of prescribers and pharmacists in charge of quantifying the needs for rational orders (combined molecules, cheaper, bulk orders, adjusted and in adequate amounts). ESTHERAID also promotes the establishment of early warning indicators to stock-outs (like AMDS indicators, THE AIDS Medicines and Diagnostics Service) and facilitates inventory management by adapted software (MEDICSTOCK), in Benin.

(146) In Burkina Faso, and also in the other countries, the ESTHERAID project activities are integrated in the action plan of the Ministry of Health. There is a strong involvement of the authorities in the implementation of project activities (Ministry of Health, DG hospitals, and actors of case management). The Secretary General of the Ministry of Health chairs the ESTHERAID' project steering committee.

(147) The validation of all tools developed within the project is done with the national authorities. This is the case for ESOPE patient database, the referral tools, specimen collection, the viral load tests, and the Therapeutic Patient Education (ETP).

(148) The different partners involved in fighting against HIV also share views in various regular meetings:

- The National Committee for monitoring and management of ARVs and other supplies to respond to the HIV epidemic.
- The Steering Committee of the ESTHERAID project
- Supervisions done by the steering committee at the peripheral sites.

(149) The resulting coordination and sustainability is demonstrated by the example of Burkina where currently the reagents to measure viral loads in HDJ were provided by the MoH.

(150) ESTHERAID aims to extend access to HIV supplies including ARVs, facilitating and securing their availability and ensuring their proper use at eleven treatment sites. To reduce disruptions of ARVs for causes attributable to inventory management, a number of activities are carried out:

- The development of normative documents and pharmaceutical guidelines;
- The development of manuals of good practice for storage and distribution of HIV drugs and diagnostic supplies;
- And the trainings mentioned earlier: Training of trainers and actors in tools for distribution, and;
- Training of prescribers and pharmacists in charge of quantifying the needs for rational orders.

Various types of trainings, that will anchor the achievements of the programme, are taking place and are at different stages of progress in the five countries.

12. Are the transition/exit strategies in place; are sources of funding identified, available and used?

(151) In the CHAI project, the "UNITAID and CHAI discussions on the exit/transition strategy focused primarily on alternative sources of funding for the commodities, and did not touch upon the continuation of support activities" (Mid-Term Review CHAI Second-Line Project Feb. 2012).

(152) "Although deemed critical, support activities for the effective ordering, receipt and use of drugs were not considered. Once the transition was completed, there was no assurance either that these support activities would be funded under a Global Fund grant or by other donors."

(153) The ESTHERAID project implemented most of its activities in line with this recommendation of the MTR of the CHAI Second-Line Project: "Funding for support activities aimed at helping countries in effective ordering, receiving and use of medicines, should be earmarked as part of the transition plan. This would ensure that countries, which were over-relying on CHAI expertise, manage their transition smoothly."

(154) The ESTHERAID programme does improve data collection and required forecasting, but experience has shown that orders or market contracts may be invalidated by the GF, and that causes a breach in the logical process and time sequence. In the assumptions of the logical framework of the ESTHERAID programme, the support for funding and procurement was not included because of the liability of other partners and national authorities.

(155) Concerning the establishment of a transition plan, that is to say for national stakeholders to be in charge of ensuring efficient use of the supplies reaching the country, ESTHERAID could play its role of technical partner of national authorities to put measures in place for continuity in efficient use of the supplies. The strong position of ESTHER in these countries is an asset for these national measures to be developed with partners and beneficiaries, and thus to be adapted accordingly, and to remain operational.

(156) However, the main obstacle to the programme is that strengthening of the supply chain is irrelevant if there are no supplies in the pipeline. Accordingly, a key factor of sustainability requires activities in collaboration with other donors, to ensure that supplies are available.

(157) The ESTHERAID strategy is to strengthen national capacities throughout the whole cycle and through increasing participation in the CPP, it could also cover pharmaceutical procurement processes at higher level, including financing and the purchase.

(158) It is beneficial to strengthen technical assistance throughout the procurement process: the PSM plan, procurement and tracking orders need to ensure consistency between ESTHERAID and other implementers receiving funds from UNITAID, and allows to check orders for 2nd line and paediatric ARVs against market prices that providers charge to countries for those products (costs are charged to countries and resulting in potential budget deficit).

(159) Intervention and systems improvements at central and district level, in Burkina Faso as in the other programme countries, are done together with the national authorities, and will survive the programme through institutional anchorage. For instance, one of the objectives of the ESTHERAID project is to reduce stock-outs of supplies. To this end, in Burkina Faso, a cluster of activities is dedicated to this issue at the General Directorate of Pharmacy, Medicines and

Laboratories (DGPML), a central partner of the ESTHERAID project. The DGPML pilots the National Monitoring and Management Committee for ARVs and other supplies that are key to respond to the HIV epidemic.

(160) In order to secure supply of sensitive pharmaceutical products, and following a 2010 recommendation by the Board of Directors of the ministerial sector (CASEM) of the Ministry of Health, the committee was formalized by a ministerial decree and is functional since 2011. The establishment of this committee was the result of the cooperation between the various partners involved (DGPML, PSSLS, DSF, PADS, DMP/Ministry of Health, DAF/Ministry of Health, CAMEG, CHU-YO, SP-CNLS-IST, the National Association of Pharmacists, the National Association of Physicians, the TFP of the Ministry of Health).

(161) The responsibilities of this committee are:

- Coordinate activities related to the sound management of ARVs and other supplies to the HIV response at national level, ranging from needs assessment to use in the field;
- Coordinate the development and monitoring of the implementation of plans relating to the procurement of ARV stocks and other supplies in response to the HIV epidemic by the different actors involved;
- Ensure the establishment and effective functioning of a coordinated data system for the management of ARVs and other supplies in response against HIV;
- Ensure rational use of ARVs and other supplies in the response to the HIV epidemic according to the standards and protocols in force in Burkina Faso;
- Monitor the quality and cost of ARVs and other supplies in the response to the HIV epidemic;
- Support the monitoring of risks and adverse events.

(162) Given these different roles, it was decided to hold quarterly meetings, preceded by subcommittee meetings for quantification and for monitoring of the procurement plan. Committee meetings are held regularly, 7 in 2011 and 7 in 2012. The functioning of this committee is supported by ESTHERAID[30].

(163) The completion of the ESTHERAID project should not have a negative impact on the continuous supply and distribution of drugs and reagents for case management of PLWHA. Indeed, the project does not directly affect purchase.

(164) ESTHERAID participates on the committee meetings but *does not act as a source of funds* for the provision of drugs and reagents. ESTHERAID does support the strengthening of the distribution system and thus the availability of HIV supplies, that are already in the pipeline. However, in several countries ESTHERAID participated in some consultations and brainstorming on the issue of transition of funding sources (e.g. in CAR and Cameroon).

[30] In Cameroon the MoH issued a memo concerning the establishment of ad hoc committees, responsible for coordinating procurement and tracking the inventory of supplies of the PNLS, with the establishment of regional units and a central cell with quarterly meeting. The regional units hold monthly meetings with reports on update of orders, supplies, consumption, and inventory of available supplies, as well as on the number of patients under ARV treatment.

(165) ESTHERAID supported the draft of National Procurement and Supply Management (PSM) guidelines in three countries[31]. In Mali, the situation was particular. There was already an existing procurement coordination mechanism (the Malian supply chain management named MCSA[32]), which later was put on a hold when Mali had to comply with the Voluntary Pooled Procurement (VPP) for the next round of the GF. There was no problem of stocks until supplies financed by the Global Fund had to be made through the VPP and not by the national level. The opinion is that it would have been better and more sustainable to strengthen this national mechanism (with ESTHERAID among others) rather than replace it with a system of VPP. VPP mechanisms are now installed in four of the five ESTHERAID countries (except Benin).

Other sources of funding[33]

(166) The GFATM is used to finance projects that will only focus on a specific part of the supply chain but that do not cover the full therapeutic cycle. USAID is financing a somewhat similar project in Cameroun called 'Systems for Improved Access to Pharmaceuticals and Services' (SIAPS), which is implemented by a team led by Management Sciences for Health. However ESTHER is not eligible to obtain financing from USAID. When looking at the EU Programme called 'Investing in people' (http://ec.europa.eu/europeaid/how/finance/dci/investing_en.htm), there could be an opportunity to receive funding through a call for proposals under the priority 'Good health for all' for a project like ESTHERAID.

(167) In the context of country coordination for West and Central Africa, UNITAID has requested ESTHER to be more proactive on the international scheme through integration with the Coordinated Procurement Planning-initiative (CPP[34]).

(168) In January 2013, the ESTHER pharmacist in charge of the pharmaceutical technical assistance in the ESTHERAID project and back up of the programme has been appointed as ESTHER focal point in the technical work group of CPP. The CPP technical work group tries to deal with stock outs. ESTHER is also represented and participates at the JURTA workgroup, the 'Joint UN

[31] Benin, Burkina Faso and Cameroon

[32] MCSA is a Malian mechanism that existed before the programme Estheraid, and included the national and regional actors on all issues of supply of ARVs in the country: the National High Council for the Fight against AIDS (HCNLS) Pharmacie Populaire du Mali (PPM), the unit for sectoral fight against AIDS (CSLS) of the Ministry of Health, Directorate of Pharmacy and Medicines and National Directorate of Health. This mechanism was a technical component for the procurement. MCSA acted as a sentinel, following closely the supplies and warning, proposing solutions, attracting the attention of policymakers to avoid stock-outs or other problems related to supply. It is only to be hoped that the VPP installed by the GF reaches the same level of safety.

[33] In the CAR, the ESTHERAID management is actively advocating with UNITAID and other donors to ensure supplies. ESTHERAID also promotes national ownership that is already engaged with the project partner institutions, through various meetings of the steering committee and through involving all stakeholders.

[34] Strengthening the supply of HIV/AIDS commodities through donor coordination: as key donors recognized their growing interdependency in country operations and the need to coordinate their efforts under the Three Ones principle, the CPP initiative provides a framework to improve and strengthen country-level coordination for the planning and procurement of HIV/AIDS related commodities. The initiative is in line with the Paris Declaration and the Accra Agenda for Action (AAA) endorsed at the recent high level Forum on Aid effectiveness.

Regional Team on AIDS' (JURTA) for West and Central Africa (WCA)[35].

(169) But both initiatives of donor coordination do not deal primarily with funding, as the CPP framework is established to improve and strengthen country-level coordination for the planning and procurement of HIV/AIDS related commodities. And the JURTA is an equivalent for Francophone African countries[36].

(170) At the same time, governments are looking for other sources of funding:

African countries, which contain many of the communities most affected by the AIDS pandemic and receive the bulk of Global Fund money, are adopting innovative methods to finance the fight against the disease in the face of declining resources from the Fund in recent years. In 2011, Cameroon joined Congo, Madagascar, Mali, Mauritius and Niger in applying an airline levy[37].

2.1.6. Conclusion

(171) The ESTHERAID programme remains highly relevant. Efficiency did improve where ESTHERAID had a say, all along the chain from supply management and financial management and procedures, to distribution and quality delivery to final beneficiaries. But ESTHERAID can hardly influence the availability of supplies at country level and budgets.

(172) Effectiveness is already evident in several key areas like strengthening healthcare supply and information systems and is likely to reach the expected quantitative targets.

(173) Impact will depend on the effective implementation for the remainder of the programme and hinges on factors of instability in the region.

(174) Although it was a request from UNITAID to the evaluators to assess how the CHAI project drugs were used, the reality is that in Benin for instance, the ESTHERAID project started after the withdrawal of the CHAI.

(175) Training and supply management improvements have contributed effectively towards limitation of stock-outs.

(176) Quality of care has benefited of both supply management and holistic care for PLWHA.

(177) The exit/transition strategy is enforced in this project through advocacy with other donors (including UNITAID), and promoting national ownership already engaged (project partner institutions) through the various meetings of the steering committee and involving all stakeholders.

(178) Involving all the stakeholders is a continuous process that also needs renegotiation. Where the programme reached agreements with governments, it is more difficult to align with big players

[35] The 'Joint UN Regional Team on AIDS' (JURTA) for West and Central Africa (WCA), has a procurement and supply management group to identify and prevent stock issues and the advocacy role related to it.

[36] Niger, Burkina Faso, Benin, Ivory Coast and Senegal.

[37] AIDSPAN Global Fund Observer, Newsletter, Issue 209: 12 February 2013

as the GF and its VPP.

(179) The strength of ESTHERAID is to have built in the process the ownership and participation of the governments, partners and relevant authorities on HIV/AIDS, strengthening their capacity and motivation to take the leadership after project completion, and thus ensuring sustainability.

(180) Where the transition of the CHAI project was weak regarding "the support activities for the *effective ordering, receipt and use of drugs*", it became the first task of ESTHERAID to ensure smooth transition and this where they have put the bulk of their energy. ESTHER will have to follow up and see how they can reinforce advocacy, political lobbying and international *networking to ensure in-country budgets availability*, and to look out for international bulk ordering of *drugs and supplies at prices negotiated* by UNITAID and by the CHAI Second-Line Project.

(181) Public money should be translated into public health. In line with this principle, ESTHERAID contributes to efficiently use supplies by building up quality assurance for the release of products.

(182) ESTHERAID improves data collection and required forecasting, but has little influence on orders or market contracts that may be invalidated by GF, and that in turn challenges, or prevents the efforts for forecasting to reap results.

2.2. Implementation issues

2.2.1. Stock security or stock failures

(183) Although a lot has improved in securing the supplies of 2nd line ARVs for adults, paediatric ARVS, and laboratory reagents since the first full year of implementation, 2012 has not been without problems.

(184) ESTHER played a facilitating role to overcome deadlock in **Benin**. The process of contract finalization was initially slowed down because the contractual transition from the GF HIV/AIDS grant Round 5 to Round 9 between secondary funds' recipients[38] and primary funds' recipients had to be finalized. That required confirmation of relevance of ESTHERAID year 1 activities, planning adjustment and definition of roles and responsibilities of supported institutions.

(185) The increase in the number of patients cannot be rationalized, since the occurrence of stock-out of reagents for screening, or delivery of reagents of poor quality, will sometimes interrupt screening for several weeks or months, for example when **Benin** experienced dysfunction between 2010 and 2011, it resulted in an increase of patients treated by only 0.3%, while in 2009-2010 it was 27% and from 2011 to 2012 it was 15.59%.

(186) The delay of the signature for the second phase of the GF Round 8 and the change of the Principal Recipient had also an impact on the project in **Mali**. In absence of the GF, Mali has been able to auto-finance for two years the provision of ARVs.

(187) The situation is similarly critical in Cameroon, leading to shortages in ARVs and laboratory supplies.

(188) In Benin, stock-outs of inputs do paralyze major project activities and cause central demoralization as well as at supplies level. The ESTHERAID project has no control over it, but will do better in near future by setting up a more reliable early warning system and forecasting.

(189) In Cameroon, control of stock-outs has improved: there is the opportunity to redeploy products overstocked at the National Warehouse, a mitigation strategy unveiled during coordination meetings on procurement, an activity that was supported by ESTHERAID.

(190) Stock failures are not always due to malfunction of the pharmaceutical system and may, as has been the case, be a consequence of the difficulties of financing (the case of GF R10 in Cameroon whose release time was very long and subject to a list conditions). Here, as in other countries, ESTHERAID has worked on the 'pharmaceutical norms' that did not exist in Cameroon before.

(191) In Burkina Faso & CAR, the causes of stock-outs are not inherently related to Human Resource skills but also to the financial resources available. There are also the cumbersome procedures related to the requirements of donors (Global Fund).

[38] In Benin, the national programme (PNLS) is now primary recipient, and the Central Store (CAME) the secondary recipient, responsible for procurement and it also assigns storage and distribution. The MoH does the quantification.

(192) The uncertainty regarding access to paediatric ARV, Dry Blood Spot Specimens (DBS) and screening tests for children was a major obstacle for the decentralization of care in the Central African Republic.

(193) Stock-outs are reported based on the indicator of days that tracer drugs are not available. The numbers for 2012 are not yet known, in order to compare with the bad year 2011. Stock-outs do not necessarily mean that patients are not treated. The problem is that the monitoring system does not show how the search for borrowed or replacement drugs, and the substitution of fixed dose combination by dissociated drugs, is straining the staff and is time consuming.

(194) A year ago ESTHERAID agreed with UNITAID on a simplified list of tracer ARVs as it was a big challenge to collect understandable data for the 2011 annual report. For children one tracer was identified 1L FDC + LPVr paediatric dosage; For adults: LPVr, ATV/r and one FDC with TDF (no more ddi).

Table 5: Percentage of respondents that claim that stock out persists in 2012:

	Country											
	BF		BE		MALI		CAM		CAR		Total	
Respondant category	Number of yes	Number of answers	Number of yes	Number of answers	Number of yes	Number of answers	Number of yes	Number of answers	Number of yes	Number of answers	Number of yes	Number of answers
Medical staff	5	15	4	5	4	5	NA	0	0	1	13	26
Pharmacists	2	12	3	5	1	1	2	3	0	2	8	23
Total	7	27	7	10	5	6	2	3	0	3	21	49

	Country					
Respondant category	BF	BE	MALI	CAM	CAR	Total
Medical staff	33%	80%	80%	NA	0%	**50%**
Pharmacists	17%	60%	100%	67%	0%	**35%**
Total	**26%**	**70%**	**83%**	**67%**	**0%**	**43%**

(195) To further observations in this area, it must be noted that the safety procedures to deal with stock-outs and to secure treatments are similar in the five countries:

- The **Cameroon** assess the stock of medicines and anticipate by giving treatment for 15 days, 10 days, 5 days, and those far away receive three weeks treatment to wait for the next supply.
- In the **CAR**, the UCM (Unité de Cession du Médicament) has not registered stock-out of ARV treatment for PLWHA children. They resort to lending opportunities between programs or inter-country.
- As part of the transition to the revised protocol as recommended by the WHO, the ruptures observed concern ARVs whose protocols are no longer applied.
- The unit has appropriate dosage forms (dispersible paediatric tablet, fixed-dose forms and dissociated)
- In **Benin,** the provider tries to substitute the ARV by another molecule, those who can pay go elsewhere, or troubleshooting is done near other centres that have enough stock. Another strategy is the reduction of the number of days of treatment delivered, or to

negotiate with other sites to help out, and later reimburse.

- In case of stock-outs of diagnostic reagents, the staff simply limits its diagnosis to the clinical status of the patient.
- For stock-out of ARVs, in **Benin** it is juggling, switching from one molecule to another!
- **In Mali:** there is no alternative source than suspending prescription patterns.
- **In Mali:** there is no alternative source than suspending prescription patterns. Just as is the case in **Burkina Faso:** When combined forms have come to miss, dissociated forms were provided (AZT/3TC AZT/3TC/NVP + NVP and TDF / FTC + EFV to TDF / FTC / FTC).
- Reagents for screening are purchased on the market, and reagents for biology (CD4) are received from the government. In case of stock-outs of reactive CD4 a letter is sent to PSSLS to inform.
- The collaboration between colleagues buys time to solve stock-out problems.
- In **Burkina Faso** all this is essentially a consequence of bad forecasting and lack of reliable data on drug consumption along with decrease of The Global Fund contribution that only covers 70% of overall needs in HIV Round 10 down from 90% to 95% previously in Round 6.

Table 6: Percentage of respondents that claim that supply of ARV-2nd line drugs is well and always ensured

	Country											
	BF		BE		MALI		CAM		CAR			
Respondant category	Number of yes	Number of answers	Number of yes	Number of answers	Number of yes	Number of answers	Number of yes	Number of answers	Number of yes	Number of answers	Total yes	Total answers
Medical staff	13	15	2	5	4	5	NA	0	1	1	20	26
Pharmacists	10	10	5	6	1	1	1	6	4	4	21	27
Total	23	25	7	11	5	6	1	6	5	5	41	53

	Country					
Respondant category	BF	BE	MALI	CAM	CAR	Total
Medical staff	87%	40%	80%	NA	100%	**77%**
Pharmacists	100%	83%	100%	17%	100%	**78%**
Total	**92%**	**64%**	**83%**	**17%**	**100%**	**77%**

Table 7: Percentage of respondents that claim that supply of paediatric ARV drugs is well and always ensured

	Country											
	BF		BE		MALI		CAM		CAR		Total	
Respondant category	Number of yes	Number of answers	Number of yes	Number of answers	Number of yes	Number of answers	Number of yes	Number of answers	Number of yes	Number of answers	Number of yes	Number of answers
Medical staff	8	10	0	5	5	5	NA	0	1	1	14	21
Pharmacists	9	10	4	5	0	0	3	6	4	4	20	25
Total	17	20	4	10	5	5	3	6	5	5	34	46

	Country					
Respondant category	BF	BE	MALI	CAM	CAR	Total
Medical staff	80%	0%	100%	NA	100%	**67%**
Pharmacists	90%	80%	NA	50%	100%	**80%**
Total	**85%**	**40%**	**100%**	**50%**	**100%**	**74%**

Table 8: Percentage respondents that claim that supply of tests and diagnostic reagents is well and always ensured

	Country											
	BF		BE		MALI		CAM		CAR		Total	
Respondant category	Number of yes	Number of answers	Number of yes	Number of answers	Number of yes	Number of answers	Number of yes	Number of answers	Number of yes	Number of answers	Number of yes	Number of answers
Lab staff	5	8	1	2	NA	0	NA	0	NA	0	6	10
Medical staff	8	14	1	5	3	5	NA	0	1	1	13	25
Pharmacists	7	9	1	3	0	1	0	3	3	4	11	20
Total	20	31	3	10	3	6	0	3	4	5	30	55

	Country					
Respondant category	BF	BE	MALI	CAM	CAR	Total
Lab staff	63%	50%	NA	NA	NA	**60%**
Medical staff	57%	20%	60%	NA	100%	**52%**
Pharmacists	78%	33%	0%	0%	75%	**55%**
Total	**65%**	**30%**	**50%**	**0%**	**80%**	**55%**

2.2.2. Access

(196) The ease of access is related to distance, and is improved by decentralisation of the sites (next paragraph). Access is also related to the availability of drugs and reagents (stock-out of reagents for screening, or delivery of reagents of poor quality will sometimes interrupt screening for several weeks or months).

(197) Moreover, access is influenced by price, which UNITAID tries to influence through market mechanisms. In Burkina Faso, at this moment a laboratory uses own reagents for biological monitoring of PLWHA, the patient pays lump sum of 3,000 CFA (6 USD), adding to this transport costs and treatment.

(198) Also in other countries (Benin), the laboratory purchases supplies on own budget, or with partial support from partners as APTAA (The Association for the Provision of Therapies for AIDS in Africa, created in 2000) and ESTHERAID.

2.2.3. Trainers

(199) Due to the very specific and large demand for the training of pharmacists, more specialized expertise (international) is needed, which takes more time to contract.

(200) The team examined the relative advantages of an International Technical Assistant (ITA) over the alternative National Technical Assistant (NTA).

(201) Certainly the costs are different:

- The cost of an in-house ESTHER expert is almost 60% lower than an external international consultant. When time did not permit to assign an ITA, a NTA replaced to ITA, being 80% less expensive than an ITA. Based on ESTHER networking, a number of activities are implemented through twinning with French hospitals. Those experts are 40% less expensive than an ITA.
- Pros and cons were discussed: In Cameroon one single ITA has significantly contributed to the process of improving quantification of supplies. NTAs have the flexibility to adjust to the methodological approach; they can share new experiences and have a view on the last developments in case management of HIV/AIDS and OI.
- But generally it is conceded that both ITA and NTA are complementary, as well as the twinning hospitals.
- Besides the lower cost, the NTA has the advantage of a better knowledge of the field, of the available resources and constraints, and he adapts better to the cultural and sociological reality in the field.
- The problem with ITAs, as was experienced in the CAR, is the difficulty in mobilizing timely the necessary international expertise. In Benin it is felt that the ITAs tend to reduce the mobilisation of the beneficiaries and stakeholders; whereas the NTA is able to facilitate a participatory model, as long as the selection procedure is transparent (an important criterion to assure the quality of a NTA).

- Mali cannot provide feedback on ITA as the process has yet to start with the first recruitment of an ITA foreseen on 1 March 2013

2.2.4. Decentralisation and networking

(202) It was mentioned above how networking between distribution centres and central stores had smoothed and reduced gaps in the arrival of drugs and supplies. In Burkina Faso, the networking has kept improving the organization and quality of HIV care in the decentralized locations, and has strengthened the collaboration with the higher level.

(203) Also better inter-institutional collaboration (as through ACAME), and the inclusion of the tutoring hospitals, strengthened the whole chain of competence for HIV/AIDS care and treatment, and improved the interagency collaboration, particularly with the reference levels (tutor hospital and laboratory).

(204) Strong involvement of diverse patient associations in the monitoring and support facilitated adherence of patients to treatment and contributed to facilitating the search for defaulters.

(205) The implementation of therapeutic committees has influenced upstream the availability of supplies and strengthened the coordination of regular monitoring of activities and supplies.

(206) As a conclusion: Decentralisation opens doors for better collaboration with associations and relevant committees and quality improvements in the treatment of patients.

2.3. Project management

(207) Mandate and business models of UNITAID and ESTHER are fundamentally different and only converge and are complementary on the objective of"contributing to scaling up the access to treatment for HIV/AIDS". Both UNITAID and ESTHER want to make sure that the products they selected reach the people in need. Access is used in its widest definition of quality products and their delivery at the lowest price.

(208) Three levels are considered important in the implementation and also in the exit/transition strategy of ESTHERAID: effective ordering, receiving and use of medicines.

(209) As summarised in the introduction, the CHAI Second-Line Project (from March 2007-December 2011) focused on procurement of second-line treatments. CHAI also carried out upstream and downstream activities such as: forecasting needs in collaboration with each beneficiary country; submitting countries' orders; planning for receipt, clearance, storage, and distribution of drugs; and confirming the delivery of drugs in order to trigger payment to suppliers.

(210) One of the main challenges for CHAI has been ensuring transition to other funding sources and helping countries to pool their orders.

(211) In addition to its procurement functions, CHAI was responsible for providing technical support to countries to ensure the effective ordering, receipt, and use of project drugs, which amounted to 1% of the available budget.

(212) By the time ESTHERAID project took off, like mid 2011, the CHAI project was coming to an end[39].

(213) ESTHERAID, as per its mandate is now replacing CHAI for providing technical support, but its mandate is limited to technical support.

(214) This also has implications for the exit/transition strategy of ESTHERAID: with its objective defined as "effective ordering, receiving and use of medicines in five francophone African countries", ESTHERAID makes use of its knowhow and twinning strategy to reach its objectives. But ESTHERAID has no budget to supply drugs and procurement is not in the perimeter of its intervention.

(215) The exit/transition strategy of ESTHERAID is therefore legitimately focused on support activities for the effective ordering, receipt and use of drugs. Although its activities are directly impacted by supply of commodities, it is not ESTHERAID primary task to seek alternative sources of funding for the procurement of commodities.

(216) ESTHERAID has standardised formats that are used for reporting by the country managers (CP ESTHERAIDs):

- An Excel file reports activities on a monthly basis;
- There is a monthly monitoring report based on project indicators for ESTHERAID, an Excel file that collects the output indicators, based on the logical framework and taking into account the differences, planning, comments, and budget, which are then reported bi-annually;
- A file tracking the trainings, quarterly reported;
- A file tracking Technical assistance (NTA, ITA, and twinning) and monitoring expertise on a quarterly basis;
- A matrix of monthly budget monitoring is reported quarterly.

2.3.1. Financial management

(217) Interviews were held with the Budget and Finance Officer at UNITAID, and the Responsible for financial management and Focal Point ESTHERAID at ESTHER. The accounting system used to register the expenditures of the project is transparent and clear. The agreements that are signed with service providers clearly indicate which part of the activities (or sub-activities) falls under their responsibility and specify to which objective these activities are associated. Each sub activity has its own internal code, so that they can be easily linked to the related activity or cluster. This enables ESTHER to exactly know how much has been spent, ventilated per activity.

(218) The expenditures indicated in the financial reports are the amounts of invoices paid. From an accounting point of view this is logical, but from an operational point of view this means that the reported figures do not reflect the real disbursement levels required to implement

[39] In Benin the EA project started after the withdrawal of the CHAI.

activities during the reporting period. Some activities that have been completed during a specific reporting period, but which have not been invoiced and paid for, are not accounted for in the financial report of the related progress report. It would therefore be useful that for future financial reporting, an extra column be included in the reports indicating the estimated committed amount per objective/activity.

(219) It needs to be noted that this estimated amount may differ slightly from the actual amounts, but it will enable UNITAID to get a better understanding of what part of the budget has been actually used during a specific reporting period.

2.3.2. Internal project real time monitoring and reporting

(220) Regular field *supervisions* ensure the quality of support provided by the project.

(221) Treatment sites receive a semi-annual visit, discussed at the steering committee every six months (2-monthly in BF).

(222) Most of information compiled in reports by ESTHER is reported by country. Although it is interesting to be informed on specific and different constraints in the five countries, there is lack of an overall picture. The reports do not necessarily reflect on what is important and essential for UNITAID. Annual and semi-annual reports are structured by country and not along themes that could give a global picture of UNITAID/ESTHERAID larger impact. A number of specific issues are not directly recognizable from the reports as there are lessons learned from changes and interventions in quality of care, or other key issues as coordination of procurement planning, changes and improvements attributable to training and ToT, essential transition issues including securing budgets to purchasing supplies, evolution in- and remedies to- stock-outs, improvement of demand and distribution of drugs to patients.

(223) The countries use as indicators of progress (i) the *number of adults receiving 2nd line treatment and the number of children on ARV*, (ii) activities implemented (means utilised against total programmed for the entire project*), and (iii) *the rate of budget absorption*.

(224) The *Number of activities carried out* is compliant with the forecasts (planned activities[40]), and *the rate of budget absorption*, but over a larger period of time. Some of these indicators are presented in Table 2. The Internal project real time monitoring is essentially limited to Stock taking of the Number of activities carried out, verified on compliance with the forecasts (planned activities), and the rate of budget absorption.

(225) Regular field (joint with PSSLS in Burkina Faso) supervisions ensure integration and quality of the support provided.

(226) To align the indicators of both stakeholders, UNITAID and ESTHER, ESTHERAID was requested to develop contributions to the UNITAID Key Performance Indicators (KPI), see ANNEX 6.4.

[40] The activities are reported in numbers, but the means/activities are not "equal": some correspond with the mobilization of technical assistance for two months while others refer to a one-day workshop with two partners.

(227) The MoUs are signed for all five countries and can thus be removed from the list of KPIs. Other indicators need clarification: e.g. UNITAID contribution to country health outcomes (impact is a delayed indicator!), can only be the number of patients under treatment, and is then the same indicator as indicator 1, number of people receiving 2nd line and Paediatric drugs.

(228) A separate financial reporting could be adapted (not inside the LFM and kept for central management and reporting purposes only), and should include a column providing the amount of committed funds (not only the paid sums) to better inform on progress of activities.

(229) Finally it would be more useful for UNITAID and board members to be informed on key themes, as those used in lessons learned, as to reflect progress in processes and qualitative improvements, such as indicatively the improvements at patient level, management of stock outs and activities to secure supplies, prescription and use of drugs linked to adherence of patients to treatment and defaulters, reasons and (successful) actions taken. Another chapter could highlight ESTHERAID' steps at national and international level to coordinate procurement and inform about activities to contribute to governments planning and securing budgets for ARVs and supplies.

(230) Country analysis should come as an annex to back up the full picture of ESTHERAID' intervention and importance in the region for HIV/AIDS.

2.3.3. Managerial causes for delay

(231) As already mentioned, programming delays took place between Phase 1 and Phase 2. Also the implementation timing of initial activities was over optimistic and did not consider the availability of partners in the field, their ability to manage and appropriate the proposed changes, and to fine-tune timely the articulation between the different actors. Stock-outs, transition time between GF rounds, and political instability[41] caused delays. Additional managerial delays include:

- The administrative delays to sign and agree on financial documents;
- The late release of financial resources to make them available to the partners involved in the implementation of activities (Provision to the players on the field) between the fiduciary agency and the sites. The reason behind would be in part the 'Filemaker' software, but only for tracking expenses. The delay is also related to the degree of accuracy in the preparation of programming/ budgets;
- Another cause would be the transfer delay from ESTHER to the fiduciary agency. Once the funds are available to the fiduciary agency, everything runs fast: the delay is due to the cumbersome procedure;
- The long delay for the validation of ToR and reports, locally and at headquarters. Procedures were not clear for ESTHER, as demonstrated for the approval of the yearly report 2011. They had been waiting for approval before starting the activities for 2012, while apparently this was not necessary. Also the change in contact persons both at key

[41] political instability generated by the coup in Mali and rebellion in the Central African Republic

management posts in UNITAID and ESTHER initially caused delays.

- Feedback is not given timely, when there is a need for quick decisions; and
- Mobilization of ITA has started in Cameroon late 2012, while a number of activities remain dependent of the outputs of those ITA.

2.3.4. No-Cost extension

(232) At the moment that this review started, ESTHER had already requested UNITAID for a no-cost extension for the project. ESTHER confirmed that such a no-cost extension would be financially feasible. The budget for the first years was not fully used. The budgets that were prepared included a contingency that sometimes was not necessary, and therefore certain activities could be implemented at lower costs. ESTHER tried to use as much as possible in-house staff qualified to implement some of the activities. The cost of an in-house expert is significantly lower that of an external international consultant (almost 60% less). In some situations it was not possible to use international expertise (for example for security reasons) and a local expert (80% less expensive than an external international expert) could replace the international expert. Another alternative is twinning, 40% less expensive than an external international expert.

(233) There is a possibility to use lines of the remaining operating budget not yet signposted to scaling-up the software ESOPE and activities focused on strengthening the supply of inputs HIV.

(234) Besides savings made on the project implementation, the no-cost extension can be financed by the remaining contingency that was included in the total budget of the project. A part of this contingency has been used to cover the exchange rate loss (from US Dollars to Euros) but at this moment approximately 400 000 US Dollars are available to be used for the no-cost extension.

(235) According to ESTHER the no-cost extension is feasible if no further loss will be made on the exchange rate and if the costs of transport do not increase drastically. ESTHER will need to back up the request with a clear financial forecast and work plans. UNITAID is able to provide the ESTHERAID project with a no-cost extension up to 12 months provided the requested financial forecast and work plans are submitted and approved.

3.SWOT ANALYSIS

STRENGTHS	WEAKNESSES
- Comprehensive, in-depth technical assistance - Transparent activity- and financial reporting - Integrated regular monitoring of activities - Decentralised diagnosis and treatment sites - Networking with associations and partners - Regional (procurement) coordination platforms - Therapeutic committees - Whole chain of healthcare capacity built - ToT ensures sustainability - Improved forecasting of needs - Improved quality of care	- Delay between conception and implementation - Absence of inception phase - Misunderstanding on starting date - Administrative delays by ESTHER - Budget transfer delays by ESTHER - Possible duplications - No real-time monitoring, delayed information on indicators of progress - Multitude of processes (outputs) and outcome indicators - No clear vision on actual expenses or committed budget - ESTHER has little influence on funding and delivery of drugs
OPPORTUNITIES	**THREATS**
- ESTHER has country knowledge - ESTHER and ESTHERAID are integrated in the national system - ESTHER activities are complementary to CHAI - Use of local existing capacity - Increased access - Improved supply management, receipt, ordering, use of drugs - ESTHERAID reduces disruptions of ARVs attributable to inventory management - Sharing experiences, resources - Integrated field supervision - Availability of supplies	- Delay between phase I and II changed principal stakeholders - Programme is delayed from 6 to 11 months - Ambitious project - Large array of partner organisations (139) - Administrative burden - Distances and transport hurdles - Political instability (Mali, CAR) - Deficient central purchase of drugs and reagents due to limited budget - Access: Diagnosis not free of charge, supply interruptions, quality of supply - GF introducing parallel VPP supply system - Possible duplications

4. LESSONS LEARNED AND RECOMMENDATIONS

Motivation of the partners' alignment in the ESTHERAID programme:

Lessons learned:

(236) Although mandate and business models of UNITAID and ESTHER are fundamentally different, both converge on the objective to contribute to scaling up the access to treatment for HIV/AIDS. One of the main challenges and a strategic objective of UNITAID is to ensure that the products through its funded programs reach the point of care to patients who need them. Both UNITAID and ESTHER, through present partnership and stakeholder alignment, monitor and ensure the delivery of health care products from central pharmacies to peripheral treatment centres and finally to the patients themselves. Access is used in its widest definition of quality of products, quality of their prescription, and their delivery at the lowest price.

(237) Easier access to quality health products and services will ensure the availability in sufficient quantities and timely delivery of optimized treatments to patients. According to ESTHER there does not exist similar projects covering the strengthening of the entire supply chain of health products from diagnosis to treatment and prevention of HIV/AIDS. AS a proof of appreciation, other ESTHER African countries besides the five under review highlight the achievements of the program by expressing the need to follow a similar approach of improving the supply, demand, treatment, and information side.

Recommendation:

(238) UNITAID could revisit its model and broaden its vision in terms of market place, considering that improvement of demand and predictability of orders reduce marginal costs of ARVs and supplies.

(239) Although an atypical intervention, UNITAID has invested well in the ESTHERAID programme, which is relevant as ESTHER can leverage and complement other projects and programs financed by UNITAID, extend outreach, and increase UNITAID impact on relevant markets and on public health. Quantification and demand forecasting is difficult for these countries, yet essential to keep the prices low. It is known that predictability of orders and long-term agreements keep the marginal costs lower, while emergency orders inflate prices of supplies. ESTHERAID is dealing with country demand side, and is therefore relevant.

(240) UNITAID by embarking on this partnership meets also the ethical requirement, that public money should be translated into public health. And this is triggered by ESTHERAID contribution to efficiently use supplies while building up quality assurance for the release of products. The ESTHER activities (quality services and the demand side) are complementary to UNITAID' strive to secure availability of supplies.

Timing of the preparation phase and duration of the programme:

Lessons learned:

(241) The delay occurred between the identification/formulation (phase I) and the implementation (phase II), allowed for important changes among the technical actors and the principal stakeholders, and a different context emerged at project sites. This delay required a new formulation in a programme of 3-year duration with no foreseen inception period.

(242) At the same time, the 3-year duration underestimates the time needed to streamline and standardize systems and processes, and to introduce changes both of staff and patients' understanding and behaviour patterns (frequent stock-outs and their influence on adherence, mitigations strategies to avoid defaulters, etc.). Three years are too short for comprehensive training and attitude changes.

Recommendation:

(243) UNITAID should start this type of project with a foreseen inception period dedicated to a comprehensive update and stock taking of the real situation on the ground (as was eventually carried out), but gaps in continuity between phases need to be avoided.

(244) This type of programme (multi country, multi partners, national and decentralized levels of intervention) needs to be planned over a 5-year time span, taking into account the recommendation above of undertaking a comprehensive update and assessment at the inception phase.

(245) For this reason, to avoid losing the investment in the structure and systems strengthening and the progress already achieved, as well as to finalize key objectives, the approval of the programme extension by one year is highly recommended. ESTHER elaborated the modalities of this extension in draft work plans 2013-2014.

Project design, monitoring and reporting:

Lessons learned:

(246) ESTHERAID applies a detailed M&E of its programme, but in the comprehensive logical framework essential indicators cannot be easily identified as they are lost in the abundance of information. Despite this wealth of data, it is very hard for outsiders, including for the review team, to quickly grasp where the project stands today. This means that not all programme stakeholders use or can use, or even have knowledge of the logical framework matrix (LFM).

(247) To align the indicators of both stakeholders, UNITAID requested ESTHER, to develop ESTHERAID contributions to the UNITAID Key Performance Indicators (KPI); see ANNEX 5.5 ESTHERAID management needs to clarify some of the indicators used in the KPI table.

(248) The reports used by ESTHER are country based and not structured along themes. Although it is interesting to perceive what happens and the different constraints in the five countries, it complicates focused assessment of UNITAID contribution.

Recommendation:

(249) The LFM with essential process and outcome indicators is expected to be a guiding working tool for all staff in the ESTEHRAID programme and for all state and non-state implementing partners and stakeholders. Therefore the LFM needs to be clear and should present the main steps, objectives, expected results and OVIs in a transparent, understandable and workable way. An example is given in Annex 5.4. The lengthy descriptions of activities and assumptions were not adapted here, and the new work plan is not even included.

(250) The ESTHERAID contribution to country health outcomes can only be the number of patients under treatment, and is then the same indicator as indicator 1 of UNITAID KPIs, i.e. number of people receiving 2nd line and Paediatric drugs. Note that impact is a delayed indicator, not to be used during (short) programme time.

(251) Objectively Verifiable Indicators (OVI) of the programme LFM should (as in the key performance indicator (KPI) list for UNITAID) be applied for real-time monitoring and reporting at the end of each semester. ESTHER should agree with UNITAID on common limited simple outcome indicators.

- An outcome indicator for adults put on 2nd line treatment in those 6 months, and children on the selected paediatric ARV.
- Market outcome indicator: The increase in the uptake of adult 2nd line ARV and the paediatric tracer ARV consumption.
- The MoU is signed for all five countries and can thus be removed from the KPIs.

(252) Real time monitoring on jointly limited pre-identified process indicators, could be the following:

- Number of staff (per category) trained
- Number of days and frequency of stock outs (not necessarily tracer drugs).

(253) A separate financial reporting could be adapted (not focused on the linkage with the LFM, but kept for central management and reporting purposes only), and should include a column providing the amount of committed funds (not only the already disbursed sums) to better inform on progress of activities.

(254) Finally it would be more useful for UNITAID and board members to be informed and updated on key themes, as used in these lessons learned, and to be provided with evidence of clear progress with process indicators, on the difference made in care of patients, management of stock outs and activities to secure supplies, prescription and use of drugs with a report on adherence of patients to treatment and defaulters, reasons and (successful) actions taken. Another chapter could highlight ESTHERAID' steps at national and international level to coordinate procurement and inform about activities to contribute to governments planning and securing budgets for ARVs and supplies.

(255) Country analysis should come as an annex to back a full picture of ESTHERAID' intervention and importance in the region for HIV/AIDS. The best way to move forward is to sit with UNITAID and find out what are priorities for the organisation, concerning reporting, which indicators should be reported and at what pace.

Programme management:

Lessons learned:

(256) Many administrative delays can be avoided, like signatures of agreements and financial documents, and the release of financial resources (transfer delay from ESTHER to the fiduciary agency). The feedback on reports is overstretched, where is a need for quick decisions.

(257) Delays in the recruitment of ITA postpone activities that are downstream and hinge on their contribution, which causes a chain reaction of delays, and the validation procedures for TA recruitment are not anticipated enough.

Recommendation:

(258) ESTHER headquarters should reduce delays in validation of ToRs and reports, locally (in-country) and at HQ level, and ensure the timely provision of funds to the fiduciaries.

(259) To speed up the activities and to control the delays, the number of international external consultancy planned could be reduced and converted to local experts, twinning opportunities, or in-house experts, or including groups of multifunctional experts (as already planned by ESTHER).

(260) In countries like CAR or Mali, where some planned activities cannot proceed due to time or security constraints, priorities must be set. Other treatment centres where collaboration is easier could benefit from concentration and comprehensiveness (more in less).

Motivation of the programme and added value of training provided by ESTHER and twinning agreements:

Lessons learned:

(261) Both sections on training and on impact demonstrate that increased knowledge leads to ownership and management capacities of all levels of staff in the treatment and care centres and in the medical stores where the supplies can be more efficiently managed due to intensive training and upgrade of quality and numbers of human resources.

(262) The ESTHERAID' training programmes reinforce the roll out of databases and their application in decentralised peripheral Treatment Centres, paired with *the crucial Training of trainers* (ToT) *programme to facilitate the rollout, to cope with human resource movements and to assure sustainability*. Those activities (training and Training of Trainers) may be underestimated in other UNITAID programmes and are an added value and key element of the ESTHERAID programme, facilitating achievement of objectives and increasing expected impact of UNITAID to ensure proper supply, dispensing and ethical use of ARVs and UNITAID funds.

- More patients treated with quality 2nd line medicines
- More patients started on treatment with quality-assured child-adapted formulations, including fixed-drug combinations (FDC).

Recommendation:

(263) Therefore the training of trainers as implemented by ESTHERAID for the ESOPE database and for the Therapeutic Patient Education (ETP) is essential for the transition and is at the same time a cure for the high staff turnover in the programme countries. This (training and ToT) is a key strategy implemented by the programme!

(264) In the remaining programme period 2013-2014, the capacities and the ToT can be anchored more in-depth, and made more sustainable. Other priorities could include the consolidation of the institutional standards by sustained training, and by better application of norms and good distribution practices for pharmacy and laboratory to ensure implementation beyond the programme.

ESHTERAID' role in market dynamics and procurement coordination:

Lessons learned:

(265) ESTHERAID does not deal directly with stock failures, because ESTHERAID has no budget to buy drugs supplies, which the CHAI Second-Line Project definitely had, but CHAI was winding up when ESTHERAID' activities finally started. In the assumptions of the logical framework of the ESTHERAID programme, the support for funding and procurement was not included because of the liability of other partners[42] and national authorities.

(266) Most stock failures are a consequence of the difficulties of securing budgets and of financing supplies. This is the level where, besides careful quantification and forecasting, awareness raising and advocacy could provide positive results.

(267) The Global Fund introduced compulsory Voluntary Pooled Procurement (VPP) in four of the five programme countries, which disrupted or interrupted existing and well functioning procurement systems (as the MCSA in Mali).

(268) With system strengthening, ESTHERAID contributes to reduce the disruptions of ARVs attributable to inventory management and weak forecasting and improves prescription practices and the rightly use of drugs and diagnostic supplies by training the implementers.

Recommendation:

(269) The most important part of the interventions securing transition will remain focused on improved management and optimized use of drugs and reagents in the peripheral treatment centres.

(270) Basket funding with one structure only, to make purchases, and one single gateway to all supplies is a scenario to explore. But this suggests coordination and alignment of the principal donors. In spite of and, ESTHER and its country managers in ESTHERAID, should use the extra year to revive the Paris Declaration and the Accra Agenda for Action (AAA) to increase Aid effectiveness and promote such necessary coordination and alignment of donors. To contribute to a strategic objective of UNITAID, the programme and country managers should

[42] as there are CHAI/UNITAID, UNICEF, GFATM

scale up their active participation in international and regional African forums to lobby and advocate more strongly in the remaining period in CPP, JURTA and conferences elsewhere. ESTHER could easily use the unique chance of its present credibility in the 5 Francophone African countries and its position amongst the HIV/AIDS players to coordinate procurement and discuss forecasting and preparation of budgets by states and Technical and Financial Partners (TFP) in the coming 2 years.

ESHTERAID management of the extension period and passage to transition:

Lessons learned:

(271) The teams of ESTHERAID developed in January 2013 work plans where pharmacy activities refocus to sites rather than continue central support, because the impact is greater for improving access to treatment for patients (strengthen management skills and distribution to treatment sites, needs assessment in dispensing sites, coordination and communication between the different sites and the central level). The impact of pharmaceutical activities conducted at central level for structuring health systems (updated pharmaceutical standards and procedures, updating quality assurance procedures) has an overall effect on the long term but does not deliver a clear short term impact on access to ARV paediatric and 2nd line quality treatment. It was a main and very useful activity up to date but because of the programme running short of time it will not be kept as priority for the revised work plan.

(272) Similarly the development and testing of an ARV management and dispensing tool for the treatment sites as presently running in Benin, is not feasible within the remaining lifetime of this programme. Technical difficulties showed up in training managers in computer networking and maintenance of computers. The new work plan proposes to modify these activities and strengthen skills in the use of paper-based tools or simple excel file for the other project countries that have significant problems in this area.

Recommendation:

(273) It is beneficial to strengthen technical assistance throughout the procurement process: the PSM plan, procurement and tracking orders need to ensure consistency between ESTHERAID and other donors receiving funds from UNITAID, and to allows to check orders for 2nd line and paediatric ARVs against market prices that providers charge to countries for those products (costs are charged to countries and resulting in potential budget deficit).

- Make sure that the institutional standards and good distribution practices for pharmacy and laboratory are consolidated beyond the programme;
- In the last year of the programme, make sure that further needs for training are addressed promptly and that supervision on compliance is done, as well as continuous education for proper monitoring of those who are already under treatment. This would include pharmaco-vigilance, viral load, and computer tools (ESOPE and tools for pharmacies).

Finally ESTHER could increase its role in market dynamics and procurement coordination and support the mandate of UNITAID, by being more vocal, and disseminate widely ESTHERAID' experience, success stories and lessons learned (see related section above).

5.ANNEXES

5.1. Terms of Reference and Inception Report

5.1.1. Terms of Reference

Technical Terms of Reference for a Request for Proposals (RfP) for a consultancy to carry out a mid-term evaluation of the ESTHERAID project

1. INTRODUCTION

1.1 Objective of the ITB (Invitation to Bid)

Mid-term evaluations are a tool that the UNITAID M&E Team uses to strengthen project management and ensure that UNITAID funded projects achieve optimal results.

The objective of the proposed consultancy is to assess the progress made towards the final objectives of UNITAID support to ESTHER for ESTHERAID. ESTHERAID provides support to 5 Francophone West African countries[1] for supply chain management of medicines and tests for HIV/AIDS in children and 2nd line patients. The review should include recommendations on how project management can be improved to help the project achieve its objectives more effectively and efficiently.

UNITAID/WHO is an organization whose activities are supported by public funding and is hosted by the World Health Organization (WHO), whose financial, procurement and HR rules it follows. Therefore, it is important that non health-related items that provide infrastructure support for the delivery of health services be cost-effective. For this reason, bidders are requested to propose the best and most cost-effective solution to meet UNITAID/WHO requirements, while ensuring a high level of service.

1.2 About UNITAID

UNITAID Mission Statement

UNITAID was established in 2006 and its mission is to contribute to the scale up of access to treatment for HIV/AIDS, malaria and tuberculosis by leveraging price reductions of quality medicines, diagnostics and related products, which are currently unaffordable or unavailable for low and middle income countries. UNITAID concentrates funding support for projects which can demonstrate an impact on the markets for medicines and diagnostics either through a reduction in the cost of medicines and diagnostics, an improvement in availability of quality formulations and suppliers or an increase in timely delivery of the required products to low and middle-income countries. UNITAID aims to support national and international efforts and complement the role of existing international institutions. For further information on UNITAID's mission, guiding principles, legal framework, procurement policies (including quality assurance standards) and current types of projects, please refer to the UNITAID web-site (www.unitaid.eu).

UNITAID projects are implemented through partner organizations (Implementers) that provide treatments, diagnostics and related products to beneficiary countries in three disease areas, HIV/AIDS,TB and malaria.The principal functions of the Secretariat are to carry out and manage the day-to-day operations of UNITAID, including implementing UNITAID’s strategy, the work plan of UNITAID as approved by the Board, managing and coordinating relationships with Partners, and coordinating and facilitating technical support and advice to the Board.

[1] Project countries are: Benin, Burkina Faso, Cameroon, Central African Republic, and Mali.

2. DESCRIPTION OF SUBJECT / PRESENT ACTIVITIES

2.1 Introduction

The service provider is expected to provide an assessment of the likelihood of the project achieving the objectives that were initially set by UNITAID and its implementing partner and of the progress of the project under mid-term review.

In addition, the service provider should provide recommendations on how to improve the effectiveness and efficiency of project management, including partner reporting on project activities and finance. The reviewers are also asked to consider how ESTHERAID could continue to support and strengthen supply chain management in the countries where it is now working and what may be required in the short term to support the project. Of particular interest is the connection between the availability of quality paediatric and 2nd line ARVs and UNITAID funding for these medicines. In addition, recommendations for how to mitigate stock outs of key medicines and tests will be required.

The review should take no more than 2 months to complete and the budget submitted to UNITAID should take into consideration the short expected duration of the project, that it is a desk review and that UNITAID expects concrete recommendations that are related to the project and that can be implemented within its life-span.

The selected provider(s) will be expected to work closely with the UNITAID Secretariat to undertake reviews of the projects using official documents, evaluation checklists, questionnaires and other associated tools that may be used to evaluate UNITAID-funded projects. UNITAID requires that the consultant(s) consider the following information:

- the legal agreements between UNITAID and its implementing partners for each project;
- the progress reports and the follow-up performed by UNITAID Portfolio Managers with regards to semi-annual and annual reports from implementing partners; and
- the financial reports from implementing partners in order to assess the relationship between the financial information provided in each progress report and the information provided on activities, results and for the associated M&E indicators.

Assessment of the above-mentioned documentation will facilitate the identification of the project's strengths, weaknesses, opportunities and threats and contribute to improving the chances that a project's end outcomes are achieved. A summary of the project is provided in the Annex and is also available on the UNITAID website, www.unitaid.eu . Service providers will be provided with project plans, legal agreements, project reports, including financial reports, from Implementing Partners as well as any other information deemed necessary to perform a thorough review of the project.

2.2 Characteristics of the provider

2.2.1 Status

The service provider shall be a public institution, a private or individual company, an international consulting group or individual, or other organization with proven expertise in:

- project appraisal, project evaluation and/or project impact assessment in the global health, public health financing or development area;
- procurement, purchasing and supply chain of health products to treat, diagnose and prevent HIV/AIDS, TB and malaria; and
- the regulatory environment for health products in low and middle income countries, particularly Africa.

In addition, the ability to communicate (written and verbal) in both English and French would be an advantage.

2.3 Work to be performed

2.3.1 Key requirements

The proposed project design, method and analysis should be adequately developed, well-integrated, well-reasoned, and appropriate to the aims of the project.

2.3.2 Key deliverables/reporting requirements

The project requiring mid-term review is UNITAID support to the ESTHERAID project for supply chain management of medicines and tests for HIV/AIDS. The review is restricted to a desk review of available documentation as well as consultation with a range of stakeholders including the UNITAID Secretariat, ESTHER, National Ministries of Health, Managers of Central Medical Stores, Pharmacists and Prescribers in local hospitals and other stakeholders that may be added over the course of the review. The evaluation questions cover the areas of relevance, effectiveness, efficiency and impact. For these reviews the questions are:

Relevance:

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

Effectiveness:

2. To what extent were the objectives of the project achieved
3. To what extent are they likely to be achieved?
4. What are the main factors influencing the achievement or non-achievement of the objectives?

Efficiency:

5. Are the project partners working closely with the relevant national authorities in the project's beneficiary countries?

Impact:

6. Can the partner organization attribute UNITAID funding to improvements in supply chain management and appropriate prescriptions?

The tasks and responsibilities for the review will include meeting with UNITAID Secretariat members and other stakeholders to:

1. review the project documentation, including project specific monitoring indicators and financial reports;
2. review the current reporting templates for both project activity and project financial reporting and suggest improvements to routine project reports and modify, if necessary, the frequency and timing of reporting;

3. provide an assessment of the project management of the project under review, including strengths, weaknesses, opportunities and threats;
4. advise on other organizations, processes and procedures that could be put into place to facilitate the procurement and management of medicines and tests for HIV/AIDS in the 5 countries of the project; and
5. advise and assist in the development of an action plan to incorporate the lessons learnt from internal project management of specific projects and partners over the course of UNITAID's operational activities.

The service provider is expected to produce a final written assessment of the project under review including recommendations to the UNITAID Secretariat on how to improve the effectiveness and efficiency of partner reporting on project activities and finance.

Bidders should submit a financial proposal (preferably in US dollars) for the work to be carried out.

2.3.3 Duration and timelines

This consultancy is for a period of 2 months. The work should start on 15 December 2012 or as soon as possible thereafter and will end on 20th February 2013.

Annex: Summary of the ESTHERAID project

Introduction and background

UNITAID-funded initiatives are generating long-term, sustainable price reductions on pediatric and second line ARVs and allowing importation of these medicines into Benin, Burkina Faso, Central African Republic, Cameroon and Mali. However, the availability and usage of these medicines remains limited at major treatment care centers (TCC) hereby impacting the quality of patient care and ART scaling up in these countries.

The three-year ESTHERAID project in Benin, Burkina Faso, Central Africa, Cameroon and Mali aims to extend the number of patients receiving pediatric and/or second-line ARVs in about 10 [8-15] selected TCC per country by strengthening the supply chain and the health system capacity. The project will in respective countries: 1) improve the performance of the ARVs supply management system from the central medical store to the selected peripheral delivery endpoints, 2) optimize the HIV care offer for an increased and rational ARVs consumption in selected TCC, and 3) improve the information systems to track, record and compile ARVs stock/consumption data as well as patients clinical information.

The total project budget is 14,229,362 USD to finance technical assistance, trainings, technical workshops for adopting standards, methodologies, tools or clarifying the roles and responsibilities of in-country stakeholders for, in particular, management of pediatric and 2nd line ARVs management. At the end of the three years, the project aims to increase the current number of infants treated with pediatric ARVs in the delivery endpoints selected in Benin, Central Africa, Cameroon and Mali and the number of patients treated with second line ARVs in the main TCC of Benin, Burkina Faso, Cameroon and Mali.

Table 1.1 Project overview

Niche	HIV/AIDS - ARV pediatric and second line ARVs
Project name	ESTHERAID project
Participant partners	Central medical stores, main hospitals and MoH of Benin, Burkina Faso, Cameroon, Central African Republic and Mali
Money holder	ESTHER
Project start date	December 15th, 2010 (MoU signature)
Project end date	September 30th, 2014
Cumulative disbursements to date	5 countries: 1,373,383€. Headquarter: 370,041€ TOTAL: 1,743,424€
Reporting period	01 January to 31 December annual report and 01 January to 30 June Semi-annual report

5.1.2. Inception report

Mid-Term Evaluation of the ESTHERAID Project

INCEPTION REPORT

DECEMBER 2012

Introduction

The French governmental aid agency ESTHER was created in March 2002 to improve access to treatment and quality care for people living with HIV / AIDS in developing countries.

ESTHER today contributes to the overall care of people living with HIV (PLHIV) in 18 countries, mainly in Africa but also in South East Asia, providing scientific, technical and financial support to partner countries. It comprises a network of sixty French hospitals involved in partnership with Southern counterparts and a hundred partner organizations. By providing expertise and financial support, ESTHER (Together for a Therapeutic Hospital Solidarity Network) aims to strengthen the capacity of stakeholders to facilitate South support of PLWHA.

The French Ministries of Health, Foreign and European Affairs, and Finance ensure the supervision of the agency. The Group also provides the secretariat of the European ESTHER Alliance that brings together a dozen countries. Finally, the Group works closely with various UN agencies: WHO, UNAIDS, UNITAID, and the Global Fund.

UNITAID was established in 2006 and its mission is to contribute to the scale up of access to treatment for HIV/AIDS, malaria and tuberculosis by leveraging price reductions of quality medicines, diagnostics and related products, which are currently unaffordable or unavailable for low and middle-income countries. UNITAID concentrates funding support for projects, which can demonstrate an impact on the markets for medicines and diagnostics, either through a reduction in the cost of medicines and diagnostics, an improvement in availability of quality formulations and suppliers or an increase in timely delivery of the required products to low and middle- income countries. UNITAID aims to support national and international efforts and complement the role of existing international institutions. UNITAID projects are implemented through partner organizations (the Implementers) that provide treatments, diagnostics and related products to beneficiary countries in three disease areas, HIV/AIDS, TB and malaria. One of the key challenges that UNITAID faces is making sure that the products it supports reach people in need.

In 2007, ESTHER first contacted UNITAID to find common grounds of partnership that culminated in the MoU signature of December 15th, 2010.
This original partnership, called “ESTHERAID”, brings UNITAID together with the French governmental aid agency ESTHER, for the first programme of its type in West Africa, to trace and ensure delivery of health products from central medical stores to local clinics down to the patients themselves.

ESTHERAID provides technical support to improve the supply chain management of UNITAID-supported health products in Benin, Burkina Faso, Cameroun, Central African Republic and Mali over a period of three years (2011-2013).

UNITAID funds either paediatric or second-line HIV treatments in all these countries, and ESTHERAID works with ministries of health to ensure their correct use at treatment centres for people living with HIV through a tailored and targeted action plan. It also works to optimize the quality of diagnosis, treatment and monitoring of patients. Each country response is customised, and ESTHERAID intends to double the amount of paediatric and second-line patients in each country. The total project budget is 14,229,362 USD to finance technical assistance, trainings, technical workshops for adopting standards, methodologies, tools or clarifying the roles and responsibilities of in- country stakeholders for, in particular, management of paediatric and 2nd line ARVs management.

The participant partners in the UNITAID programme are the Central medical stores, main hospitals and MoH of the 5 countries. The project has three main objectives in the respective countries: 1) improve the performance of the ARVs supply management system from the central medical store to the selected peripheral delivery endpoints, 2) optimize the HIV care offer for an increased and rational ARVs consumption in selected treatment care centres (TCC), and 3) improve the information systems to track, record and compile ARVs stock/consumption data as well as patients clinical information.

Proposed approach and methodology

According to the Terms of Reference (ToR - Annex 1), the review is restricted to a desk review.

The methodology that was proposed in the offer (Annex 2) has been slightly adapted but in general the approach will not change. In this paragraph we will just include these small amendments, and we will not repeat what has been proposed in the offer.

Besides the briefing session with UNITAID in Geneva, a face-to-face meeting was organized with ESTHER and the ESTHERAID team in Paris. The project team has agreed with ESTHER that regular telephone and skype meetings will be organised, and it could be necessary for the project team to meet with ESTHER one more time during the data - collection phase. The work plan has been slightly adapted and the data collection phase will overlap slightly with the data analysis phase for the reason that the projects office of ESTHER in Paris as well as in the countries are closed for Christmas and New year, and only a limited amount of data can be collected during this period.

With regards to the approach the following has been adapted:

- **Document review:** Besides the documents mentioned in the offer (ESTHERAID proposal and country proposals, legal agreements between the UNITAID and ESTHER, semi-annual and annual reports from ESTHERAID and their corresponding financial reports) other documents are included in the documents to be reviewed and analysed. These documents include the legal agreements between ESTHER and their partners, presentations prepared by ESTHERAID country managers, and the request for no cost extension.
- **Literature review:** Background literature is reviewed on topics of supply chain management, health worker challenges, and approaches for scaling up ART interventions in sub-Saharan Africa.
- **Interviews and online Surveys:** Interviews and the On-line survey will be implemented as proposed in the offer. But to ensure that the evaluation team will receive the necessary return of completed questionnaires, the in-country ESTHERAID staff will assist the evaluation team to have the questionnaires completed. The advantage of this approach is that ESTHERAID staff is in close contact and have the trust of the different stakeholders and will therefore more easily be able to obtain completed questionnaires. This will most probably allow for the evaluation team to obtain data within the short time frame.
- The implementers who will be contacted to provide information are the National Ministries of Health, Managers of Central Medical Stores, Pharmacists and Prescribers in local hospitals and other stakeholders that may be added over the course of the review. The evaluation questions below cover the areas of relevance, effectiveness, efficiency, impact, and sustainability, which include the transition to identify follow up funding for ARVs. The questionnaire sent to the implementers will be formulated in French and cover more specific areas of interest to concerned stakeholders.
- Conclusions and recommendations can relate to all stakeholders, when applicable.

Evaluation Questions and Evaluation Matrix

Relevance:

1. Are the activities and expected outputs of the project consistent with the objectives and expected outcomes as described in the project plan?
2. Has phase 1 been provided relevant contribution to phase 2 and established the strategic priorities?
3. Is the tandem UNITAID- ESTHER relevant and why?

Effectiveness:

4. To what extent were the objectives of the project achieved?
5. To what extent are they likely to be achieved?
6. What are the main factors influencing the achievement or non-achievement of the objectives?

Efficiency:

7. Are the project partners working closely with the relevant national authorities in the project's beneficiary countries?
8. Has the training of the stakeholders on the different levels improved the capacity in their daily work to benefit the final beneficiary in levels of available supplies, availability of treatment and quality of prescriptions?
9. To what extend are UNITAID supplies still available in the countries?

Impact:

10. Can the partner organization attribute UNITAID funding to improvements in supply chain management and appropriate prescriptions?

Sustainability:

11. Are the processes/systems introduced by ESTHERAID sustainable?
12. Are the transition/exit strategies in place; are sources of funding identified, available and used?

Evaluation matrix

The evaluation concerns systems' functioning and more qualitative criteria (see evaluation questions), which makes weighed criteria less useful. Weighed criteria could be used for budget consumption rates (financial performance) and advances towards KPI (consolidated yearly). These data are available for 2011, where some countries started as late as May 2011, which makes the data incomplete. The data for 2012, when countries reached cruising speed, and a more comprehensive level of implementation, will give an adequate insight, but those data become only available by March-April 2012.

Nevertheless the survey should come up with a qualitative trend of where the project is going, its relevance, and the recommendations to attain the preset objectives.

To increase the stakeholder ownership in the evaluation, the survey will give room for suggestions, where possible. The evaluation should also analyse trade-offs, the not-planned effects of the project, if there are any.

The criteria will be specified and prioritized by type of stakeholder. Criteria can be added during the construction of the data collection matrix (stakeholder questionnaire) that will be done together with ESTHER.

Criteria	Country A	Country B	Country C
Trainings received	Y	N	Y
Use of training	Y	Y	Y
Drug availability	N	Y	Y
Reagents/test availability	Y	N	N
Clients' satisfaction	Y	Y	Y
Health impact, people treated	Y	Y	Y
Available stockpiles/buffer stocks	Y	Y	Y
Funds secured	Y	Y	Y
Main challenges			
Solutions for challenges	Y	N	N
Revised strategy (ies)			
Presence of exit strategy	Y	N	N
Budget absorption %			
Analysis			

Work plan

The following work plan has been agreed upon

Timetable and Description of Activities	Tentative calendar	Deliverables
Desk study/Preparation phase 1. Detailed coordination of objectives and approach with UNITAID in Geneva(briefing session 12 .12.2012) 2. Study of project documents provided by UNITAID 3. Briefing meeting with ESTHER in Paris (18.12.2012) 4. Development of the survey design (methodical approach) 5. Formulation of specific evaluation questions	10th December – 21th December 2012 7 days Team Leader 4 days research assistant	Brief Inception Report in English – 21st December 2012
Data collection 1. Participant/partner questionnaire/interview guide (written) 2. Stakeholders interviews (phone/Skype/e-mail)	27th December 2012 – 18th January 2013 9 days Team Leader 6 days research assistant	
Data analysis 1.Analysis of the information 2. Preparation of summary of findings to be presented during debriefing session	14th January – 1st February 2013 15 days Team Leader 6 days research assistant	
Debriefing session 1.Preparation of Presentation of preliminary results/ recommendations 2.Presentation of preliminary results/ recommendations	4th - 5th February 2013 2 days Team Leader 2 days research assistant	Summary of the findings will be presented on the 5th of February 2013
Synthesis phase 1.Final analysis of the information obtained, formulation of final results and recommendations 2. Preparation of draft final report 3. Submission of draft final report	6th February – 12th February 2013 5 days Team Leader 2 days research assistant UNITAID final comments to be received before the 16th of February	Main draft report in English will be present on the 12th of February
Submission of final evaluation report *including* Executive summary, main findings, list of stakeholders interviewed, and recommendations.	18th - 20th February 2013 2 days Team Leader	Final Report: and recommendations will be presented on the 20th of February

5.1.3. Methodological fine-tuning

The review took 2 months from 14 December 2012 till 14 February 2013.

Some realistic adaptations were made to the proposed methodology.

Initially this evaluation was restricted to a desk review and intended to respond to the list of 12 questions that were part of the ToRs and the Inception Report (see ANNEX 5.1.2)

To allow for complementary information, the review team has implemented this evaluation by using a participative approach. This resulted in producing more meaningful recommendations useful to both UNITAID and ESTHERAID.

The advantage of this approach is that it allowed for the persons involved and interviewed to be more comfortable with the evaluation. It will also allow for the different stakeholders to take ownership of the results of the evaluation.

A meeting was organised with ESTHER in Paris at the start of the evaluation. ESTHER cooperated by putting the evaluation team in contact with the country managers of the 5 programme countries.

The country managers were contacted through Skype and e-mail and the questionnaires (see ANNEX 5.9) were further refined with their collaboration, ensuring that the questions were relevant and well understood.

Although the questionnaires were put on line, it was decided to circulate the questionnaires through the country managers.

The Christmas break made it difficult to contact relevant stakeholders for at least 2 weeks, and the evaluation team used the remaining 3 weeks to elaborate the questionnaire and to have it completed by the relevant stakeholders.

The assistance of the country managers was therefore essential to receive completed questionnaires. They had easier access to the different stakeholders and were therefore able to provide us with a reasonable amount of completed questionnaires (Table 1).

Table 1.: Completed questionnaires received per country and per category of stakeholder

	BF	BE	MALI	CAM	CAR	TOTAL
Laboratory	8	2	-	-	-	**10**
Drs, CSP Nurse	20	6	7	-	-	**33**
Pharmacy	12	5	1	3	2	**23**
Centr.Store	-	-	-	5	1	**6**
TOTAL	**40**	**13**	**8**	**8**	**3**	**72**

Although the sample is not representative to draw statistical conclusions for three of the five countries, it does provide evidence as to how the project is perceived and what stakeholders believe is useful and where further support is requested.

It also shows that the project is further advanced in Burkina Faso than in the other countries, which corresponds to the rate of budget consumption shown under Financial Management.

Although the response rate is too low in half of the countries, it still allows for interpretation, as the open questions contributed a lot to the understanding of the particular advances, challenges and needs of each country.

It is worth noting that despite of the spike of political instability in Mali, they were still able to send 8 responses to the questionnaires.

The questionnaires are attached in ANNEX 5.9.

5.2. List of persons met or spoken to

Name/ Position	Institutions/ other
Dr Kate Strong – Monitoring and Evaluation Officer	UNITAID
Jane Galvão- Technical Officer , HIV/AIDS	UNITAID
Kvetoslava Dzackova – Budget & Finance Officer	UNITAID
Mireille Lembwadio - Operations	UNITAID
Raquel Child – Director, Market Dynamics and operations UNITAID	UNITAID
Paloma Cuchí -HIV Portfolio Manager – Operations Unit	UNITAID
Gauri Khanna – technical officer M&E	UNITAID
Hyun Hee Ban	UNITAID
Aurélie Bonfils – Responsable médicaments – Projet ESTHERAID	ESTHER
Celia Barberousse - Responsable Suivi-Evaluation	ESTHER
Florence Maclair – Directeur Administratif & Financier	ESTHER
Pierre Mendiharat – Directeur du Département Projet	ESTHER
Philippe Doo Kingue - Assistance Technique pharmaceutique ESTHERAID	ESTHER
Xavier Gillette - Chargé de gestion financière, Point Focal ESTHERAID	ESTHER
Isaka Sonde - CPEA, Chargé de Projet ESTHERAID Burkina Faso	ESTHER
Marius Gnintoungbe- CPEA, Chargé de Projet ESTHERAID Benin	ESTHER
Backo Aboubakar- CPEA, Chargé de Projet ESTHERAID RCA	ESTHER
Carole Mimbang - CPEA, Chargé de Projet ESTHERAID Cameroun	ESTHER
Haguiratou Ouedraogo - CPEA, Chargé de Projet ESTHERAID Mali	ESTHER
Gilles Raguin – Director of ESTHER	ESTHER
Greg Martin – previous manager of ESTHERAID	Clinton Health Access Initiative

5.3. List of documents reviewed

Documents analysed
ESTHERAID Phase 1 report
ESTHERAID project proposal Benin
ESTHERAID project proposal Cameroon
ESTHERAID project proposal Burkina Faso
ESTHERAID project proposal Mali
ESTHERAID project proposal CAR
ESTHERAID semi-annual report 2011 plus annex revised country plan and financial reports
ESTHERAID annual report 2011 plus annex revised country planed and financial reports
ESTHERAID annual report 2011 plus annex revised country plan and financial reports
ESTHERAID intermediary report 2012 and financial report
UNITAID annual report 2011
Presentations prepared by country managers on each of the ESTEHRAID countries
Legal agreement between ESTHER and National Laboratory CAR and its addendum
Legal agreement between ESTHER and accountant office ARC in CAR
Memorandum request for no cost extension
CHAI Mid-Term Review CHAI Second-Line Project Feb. 2012

5.4. Simplified Logical Framework

	Intervention logic	Objectively verifiable indicators	Sources and means of verification	Assumptions & Risks
Overall objective	Project Goal (Impact): To extend the number of patients accessing paediatric and 2nd line ARV in 10 TCC distributed across all regions of Benin	Health outcome indicator G1.1: An increase in the number and percentage of infants receiving ARV in the 10 selected TCC- 50% of HIV-infected infants treated with ARV It will result in at least doubling the current number of HIV-infected infants treated with ARV Market outcome indicator P1.2: An increase in the uptake of 2nd line tracer ARV consumption in the 10 selected TCC- Doubling the uptake of patients treated with 2nd line ARV	TCC activity report from health authorities Sources of data: Patient monitoring system of the 10 respective TCC ***1.1***	Paediatric and 2nd line ARVs are imported in the country and approved for market distribution and usage in conformity to national guidelines Available funds for the procurement of paediatric and 2nd line ARVs quantities to the 10 selected TCC ESTHERAID's contributions are recognized by national authorities and implementing partners involved in access to treatment for HIV/AID The technical assistance approach required for the project success does not substitute the local expertise and accelerates the technical knowledge transfer ESTHERAID's tools and SOPs applied are integrated and aligned with national authorities decisions ESTHERAID's activities will be integrated to the respective long-term twinning arrangements planned between the selected 10 TCC and French referral hospitals
Specific objective	Project Purpose (Outcome): To strengthen the national supply chain and the health system capacity to remedy the low and/or irrational demand and consumption of paediatric and 2nd line ARV in the 10 selected TCC	Market outcome indicator P1.1: An increase in the uptake of paediatric tracer ARV consumption in the 10 selected TCC	TCC ARV supply report Sources of data: Benin CMS and TCC stock information system ***1.2***	Robust ESTHER's implementing partners are available and still aligned with ESTHERAID's programming and goal and objective The adoption of norms and implementation schedule of the different departments of MoH respectively in charge of the national supply chain and pharmaceutical affairs, clinical and laboratory good practices and HIV scaling up monitoring and evaluation

				are coordinated ESTHER's work is complementary to the other institutions working to improve access to paediatric and second line ARVs National HIV treatment guidelines for adults and children and FDC are harmonized and adopted in Benin
Expected results: **Result 1**	Output 1: Improve the PSM system from CMS/warehouses to the 10 selected TCC by applying ARV management tools in decision-taking, supply quality assurance and storage procedures and thereby ensuring a continuous supply of quality ARV to the 10 selected TCC	**Output Indicators** Number of stock outs for tracer ARV s Number of TCC with all ARV orders made while the stock on hand was within the minimum stock level in the last 12 months	TCC ARV supply report Sources of data: CAME and TCC stock information system ***1.3***	Complementary activities of non ESTHER-funded projects continue to be implemented (planned training, planned selection and installation of software at CMS, GF-funded PSM activities), b) the ARVs transportation from CMS and the 10 selected TCC is made available to ensure the quality and continuous distribution of ARVs to the 10 TCC
Activities **R 1**	Activity A1.1: Facilitate the development of an ARV supply plan with all respective in-country stakeholders currently involved in the collection of required data and quantification process 1.1.1 Optimize the data collection of ARV consumption information between stakeholders 1.1.2 Support for the ARV quantification of needs 1.1.3 Set up of coordinated supply plan Activity A1.2: Reinforce the supply chain management of paediatric and 2nd line ARV at CMS and its depots 1.2.1 Reinforcement of the CAME for managing the drugs of specific programmes 1.2.2 Support for improving effectiveness of CAME storage conditions and distribution system: update and rationalize SOPs 1.2.3 Training in the use of computer tools for stock management at CMS Activity A1.3: Reinforce the ARV storage, dispensing tracking and stock management in	**Process indicator** P1.1: A coordinated ARV supply plan developed per year - 3 annual supply plan done at the end of the project P1.2: Percentage and number of sites (CMS, depots) aligned with storage, inventory and distribution good practices SOPs implemented for paediatric and 2nd line ARV management - The CMS and the 2 depots aligned at the end of the project P1.3: % and number of TCC aligned with storage and inventory good practices SOPs implemented for paediatric and 2nd line ARV management The 10 selected TCC aligned with updated SOPs P1.4: Number of pharmacists trained - 9 study grants and 2 staff per CMS trained	Reports of: International experts National experts Twinning Grants Traineeship Equipment Software (ESOPE and others)	ARVs are procured and supplied through the national supply chain system Human resources and minimum storage equipment are made available in the 10 TCC Cold chain equipment are made available by the national authorities to ensure the good storage and transportation of cold-required ARVs Transportation is guaranteed between central medical store, depots and the 10 TCC Internships/study inscriptions are approved by universities

	the 10 selected TCC 1.3.1 Setting up of a computerized tool for the management of stocks and dispensing of ARV 1.3.2 Improvement of storage conditions of inputs and management of stocks at TCC level Activity A1.4: South capacity building in drug supply management (regional training diploma) Study grants for regional university diploma. Diploma Gestion du médicament in Ouagadougou ACAME Support for leading regional training of CMS staff in ESTHERAID benefiting countries			
Result 2	Output 2: Optimize the HIV care offer for identifying rationally treating and monitoring patients needing paediatric and 2nd line with national/WHO HIV STGs in the 10 selected TCC	**Output Indicator** Number of PCR HIV, CD4 performed Percentage of patients receiving ARV treatment regimens which are in line with national/WHO HIV STG	TCC patient monitoring report <u>Sources of data:</u> Patient monitoring system per TCC, Lab registers	No change in inputs required for implementing STG during the 3 years of the project, b) The financial access to treatment, biologic and virological examinations and care is guaranteed to the patients by the national authorities, c) UNITAID paediatric and 2nd line ARVs single dose and FDC are adopted and recognized by KOLs and national authorities
Activities **R 2**	Activity A2.1: Reinforce diagnostic capacities and biologic monitoring 2.1.1 Support for the beginning of virology (PCR) on a national scale by proposing a virology platform at CNHU 2.1.2 Ensure the functioning of standard biology equipments for monitoring patients in 10 labs 2.1.3 Support for the definition and implementation of mechanisms for the transportation of samples and the return of results to the beneficiaries of the 10 selected TCC 2.1.4 Facilitate the development and adoption of a quality assurance plan for evaluating the performance of the 10 TCC laboratories Activity A2.2: Promote the early detection of infants HIV infected and the referral of mother	**Process indicator** **P2.1:** % and number of lab aligned with updated technical, reagents storage, QA, return of results good laboratory practices SOPS implemented for CD4, HIV PCR techniques - 10 lab aligned with required SOPs at the end of the project **P2.2:** Number of HIV PCR performed - 5000 HIV PCR done at the end of the project **P2.3:** a) % and number of TCC with health professionals trained in national/WHO paediatric HIV treatment protocols, b) % and number of TCC health professional trained in national/WHO 2nd line use, c) Number of dispensers trained in applying harmonized dispensing guidelines on	Reports of: International experts National experts Twinning Grants Traineeship Equipment Software (ESOPE and others)	The regulatory status of the national referral lab is adopted for covering the lab examinations needs of the 10 selected TCC Quality of the transportation is ensured for the samples collection and return of results between the referral lab and the 10 TCC Available funds, procurement and supply of PCR HIV and CD4 lab reagents are continuously guaranteed Revised WHO 2009 HIV treatment guidelines for adults and children are adopted in Benin Human resources and materials are made available for lab examinations, early diagnosis, patient follow up and treatment prescription in the 10 selected TCC

	and children requiring antiretroviral therapy in the 10 selected TCC 2.2.1 Support to PMTCT services for increasing the opportunities for detecting mother and children requiring HIV treatment (skills and tools) 2.2.2 Transition following PMTCT: support for the definition and implementation of proactive research and monitoring mechanisms for mother, newborns and infants potentially infected Activity A2.3: Improve prescribing and dispensing practices regarding paediatric 2nd line ARV in the 10 selected TCC 2.3.1 Build capacities of health professionals in prescribing HIV paediatric anti-retroviral therapy in the 10 selected TCC 2.3.2 Build capacities of health professionals in identify HIV treatment failure and switching to 2nd line ARV in the 10 selected TCC 2.3.3 Build capacities of health professionals in rational dispensing practices related to paediatric and 2nd line ARV in the 10 selected TCC	paediatric and 2nd line ARV – 10 TCC with all prescribers trained on required and updated HIV STGs and 10 TCC with all dispensers trained on required dispensing guidelines		
Result 3	Output 3: Improve the ARV and/or HIV related inputs stock inventory information systems and patient monitoring systems in the 10 selected TCC for correlating inputs needs to cohort data and thereby optimizing paediatric and 2nd line ARV quantification and forecasting per site	**Output Indicator** Consumption rate: % of quantities consumed out of quantities ordered Number of sites with consistent paediatric and 2nd line ARV consumption and cohort data	TCC patient monitoring report, TCC stock management report <u>Sources of data:</u> patient files dataset per TCC, CAME and TCC stock information system	The technical supervisions programmed by national authorities are done as planned for ensuring the quality and timely reporting of data in addition to the planned technical assistance missions, b) CMS and depots send to the 10 selected TCC the drug quantities that have been ordered per site
Activities R 3	Activity A3.1: Reinforce stock management capacities in the pharmacy of the selected TCC 3.1.1 training at TCC on quantification methodology 3.1.2 Extension of the stock management system at TCC 3. 2 Reinforce patient monitoring capacities in the 10 selected TCC	**Process indicator** **P3.1:** % and number of TCC with a stock management tool implemented and used (staff trained, tool installed, SOPs available to order drugs, pharmacy staff entering data on a routine basis, orders sent) - 10 TCC aligned with the revised stock management tool	Reports of: International experts National experts Twinning Grants Traineeship Equipment Software (ESOPE and	Human resources (1 entry clerk per site) and materials (registers, desks, computers) are made available by the national authorities for tracking data, analyzing data and compiling data in the 10 selected TCC Adoption and maintenance of the patient monitoring and stock information systems are guaranteed by the national authorities

	3.2.1 Installation of software to monitor patient treatment at TCC level 3.2.2 Facilitate the integration of TCC supervision 3.2.3 Consolidate and centralize data and monitoring-evaluation indicators 3.3. Support implementation of selected WHO PSM performance indicators Support the management of selected PSM performance indicators 3.4 Project monitoring Project indicators review	**P3.2:** % and number of TCC with a patient monitoring tool implemented and used (staff trained, ESOPE software installed, SOPs available, data entry clerk entering data on a routine basis and reports sent) - 10 TCC aligned with the required patient monitoring tool **P3.3:** % and number of TCC reporting the AMDS/WHO PSM performance indicators - 10 TCC reporting PSM performance indicators	others)	and partners in the 10 selected TCC The national authorities and partners adopt the harmonized SOPs for integrating paediatric and 2nd line ARVs into the national patient monitoring and stock management system (SOPs regarding the data definitions, data collection, data compilation and data reporting)

5.5. UNITAID KPIs and ESTHERAID contribution

UNITAID Areas of priorities and KPIs	ESTHERAID contribution
Mission Contribute to the scale up access to treatment for HIV/AIDS for people in developing countries by leveraging price reductions of quality drugs and diagnostics, which are currently unaffordable for developing countries, and to accelerate the pace at which they are made available. **Indicator 1:** Estimated percentage of people (all ages combined) and children younger than 15 years receiving anti-retroviral therapy.	ESTHERAID output indicator includes the number and percentage of children receiving paediatric ARVs per TCC, and/or the number and percentage of patients receiving 2nd line ARVs per TCC in 5 developing countries. ESTHERAID will contribute to increase national ART coverage in the respective countries.
Goal: Using innovative, global market-based approaches to improve public health by increasing access to quality products to treat, diagnose and prevent HIV/AIDS in developing countries. **Indicator 4 (availability):** Number of UNITAID-funded HIV treatments or diagnostics in strategic rotating stockpiles, reported on annually.	ESTHERAID will contribute to increase the access to the quality paediatric and 2nd line ARVs by increasing and ensuring continuous demand and consumption of these drugs at delivery endpoints of the project zone. UNITAID-funded ARVs stock/consumption will be measured at TCC of the project zone.
Area 1: Implementation of UNITAID's Strategy 2010-2012 related to its market impact objectives **Action 4:** Shorten lead time for the delivery of medicines, diagnostics and related products to countries **Indicator 2:** Number of stock-outs prevented through the use of strategic stockpiles or planned buffer stocks known and monitored by Implementing Partners and reported to UNITAID.	By strengthening the capacity of national supply system and by reinforcing the LMIS, ESTHERAID will contribute to reduce the number of stock-outs of UNITAID-funded tracer medicines at TCC level of the project zone Stock –outs of ARV tracers will be measured over time per TCC, monitored by ESTHER implemented partners and reported to UNITAID
Area 3: UNITAID contribution to country health outcomes **Action 1:** Track treatments, diagnostics and related products delivered and estimated patients treated by UNITAID-funded projects by beneficiary country and over time **Indicator 1:** Number of treatments delivered and estimated number of patients treated known for each project on an annual basis	Number of ARVS tracers consumed and number of patients treated will be monitored at TCC level of the project zone and reported on an annual basis
Area 3: UNITAID contribution to country health outcomes **Action 4:** Identify the sources of support for operational costs in each beneficiary country at the start of each project	ESTHER will report on other sources of funds (either to ESTHER or to TCCs)

UNITAID Areas of priorities and KPIs	ESTHERAID contribution
Indicator 1: Per cent (%) of UNITAID funded projects that have a costing (US$) for operational costs and the sources of operational costs provided at the start of project funding	
Area 3: UNITAID contribution to country health outcomes **Action 5:** UNITAID implementing partners sign MoUs with national governments to commit long term support, align technologies and protocols for working with Ministries of Health. **Indicator 1:** Per cent (%) of UNITAID implementing partners that have MoUs signed with all national governments before start of the project or within Q1 of the project start year.	ESTHER will sign MoU with its implementing partners in the 5 ESTHERAID countries, including the MOH.

5.6. Summary of the expenditures

Expenditures of the 5 ESTHERAID countries (estimated figures till the 31st of December 2012)

		Total Budget of the MoU in Euro	Expenditures for 2011 (cf annual report 2011)	Estimated expenditures for 2012	Total Expenditures	Consumption rate
Benin	Objective 1	609 000 €	42 252 €	157 000 €	199 252 €	33%
	Objective 2	623 000 €	51 523 €	147 000 €	198 523 €	32%
	Objective 3	431 250 €	11 559 €	70 000 €	81 559 €	19%
	Local Administration	317 025 €	80 518 €	120 000 €	200 518 €	63%
	Total	**1 980 275 €**	**185 852 €**	**494 000 €**	**679 852 €**	**34%**
Burkina Faso	Objective 1	523 142 €	9 595 €	120 000 €	129 595 €	25%
	Objective 2	788 105 €	96 866 €	486 000 €	582 866 €	74%
	Objective 3	398 997 €	9 840 €	33 000 €	42 840 €	11%
	Local Administration	292 154 €	65 057 €	65 000 €	130 057 €	45%
	Total	**2 002 398 €**	**181 358 €**	**704 000 €**	**885 358 €**	**44%**
CAR	Objective 1	367 346 €	4 271 €	67 000 €	71 271 €	19%
	Objective 2	846 778 €	23 803 €	187 000 €	210 803 €	25%
	Objective 3	471 137 €	4 300 €	41 000 €	45 300 €	10%
	Local Administration	232 082 €	55 424 €	65 000 €	120 424 €	52%
	Total	**1 917 343 €**	**87 798 €**	**360 000 €**	**447 798 €**	**23%**
Cameroon	Objective 1	726 628 €	9 797 €	110 000 €	119 797 €	16%
	Objective 2	604 210 €	0 €	130 000 €	130 000 €	22%
	Objective 3	340 900 €	2 260 €	60 000 €	62 260 €	18%
	Local Administration	354 400 €	60 740 €	85 000 €	145 740 €	41%
	Total	**2 026 138 €**	**72 797 €**	**385 000 €**	**457 797 €**	**23%**
Mali	Objective 1	575 497 €	0 €	50 000 €	50 000 €	9%
	Objective 2	692 778 €	11 344 €	30 000 €	41 344 €	6%
	Objective 3	472 615 €	1 461 €	20 000 €	21 461 €	5%
	Local Administration	275 591 €	72 003 €	70 000 €	142 003 €	52%
	Total	**2 016 481 €**	**84 808 €**	**170 000 €**	**254 808 €**	**13%**
Total ESTHERAID without HQ		**9 942 635 €**	**612 613 €**	**2 113 000 €**	**2 725 613 €**	**27%**

The above table shows that the consumption rate has increased significantly during the 2nd year of the project. In the 1st year of the project only 6% of the budget was consumed, while in the 2nd year 21 % was used. Burkina Faso is clearly the most advanced with already 44% of the total budget used. Mali is the most lagging behind with only 13% of the budget consumed.

5.7. Decree

CAPR nord

REPUBLIQUE DU CAMEROUN
PAIX - TRAVAIL – PATRIE

MINISTERE DE LA SANTE PUBLIQUE

CABINET DU MINISTRE

SECRETARIAT GENERAL

SECRETARIAT TECHNIQUE DU BENEFICIAIRE PRINCIPAL DU FONDS MONDIAL DE LUTTE CONTRE LE SIDA, LE PALUDISME ET LA TUBERCULOSE

COMITE NATIONAL DE LUTTE CONTRE LE SIDA

GROUPE TECHNIQUE CENTRAL

SECRETARIAT PERMANENT

REPUBLIC OF CAMEROON
PEACE - WORK – FATHERLAND

MINISTRY OF PUBLIC HEALTH

MINISTER'S OFFICE

GENERAL SECRETARIAT OFFICE

TECHNICAL SECRETARIAT OF PRINCIPAL RECIPENT OF THE GLOBAL FUND FOR THE FIGHT AGAINST AIDS, MALARIA AND TUBERCULOSIS

NATIONAL AIDS CONTROL COMMITTEE

CENTRAL TECHNICAL GROUP

PERMANENT SECRETARIAT

Note de Service

N° D30 - 141 /NS/MINSANTE/SESP/SG/STBP/CAB/CNLS/GTC/SP

Portant mise en place des Comités Ad Hoc chargés de la coordination des approvisionnements et du suivi des stocks des intrants du Programme National de Lutte contre le Sida

Pour compter de la date de signature de la présente note de service, il est mis en place au sein du Ministère de la Santé Publique, des Comités Ad Hoc (national et régionaux) chargés du suivi et de la gestion des approvisionnements et des stocks des intrants du Programme National de Lutte contre le Sida. Il s'agit de :

A. CELLULES REGIONALES

- Présidents : Délégués Régionaux de Santé Publique (DRPS)
- Secrétaires : Coordonnateurs GTR/CNLS
- Membres : Responsables CAPR
  Responsables CTA/UPEC

B. CELLULE NATIONALE

- Président : Directeur de la Pharmacie et du Médicament (DPM)
- Secrétaire : SP CNLS ou son représentant
- Membres : L'Expert Technique du STBP
  Un représentant de la CENAME
  Un représentant de la DLM
  Un représentant de l'HJ/HCY

REPUBLIQUE DU CAMEROUN Republic of Cameroon PAIX - TRAVAIL - PATRIE Peace - Work - Fatherland LE MINISTRE MINISTRY OF PUBLIC HEALTH MINISTERE DE LA SANTE PUBLIQUE

CENTRE D'APPROVISIONNEMENT PHARMACEUTIQUE REGIONAL DU NORD
COURRIER ARRIVEE
Le 22/02/19
ENREGISTRE SIN° 023

Les réunions de coordination des comités régionaux seront mensuelles et les comptes-rendus desdites réunions devront faire le point des commandes, des approvisionnements, des consommations et des stocks disponibles en intrants dans le mois, ainsi que le nombre de patients sous traitements antirétroviraux, répartis par protocole.

La Cellule nationale quant à elle, tiendra des réunions trimestrielles auxquelles seront conviés les représentants des comités régionaux. Les comptes-rendus de ces réunions devront intégrer les données consolidées régionales.

J'attache du prix à l'application de la présente note de service./-

Ampliations :
- MINSANTE/CAB
- MINSANTE/SESP
- MINSANTE/SG
- MINSANTE/IGSP
- MINSANTE/DPM/DLM/DSF
- DG/CENAME
- SP/CNLS
- MANAGERS/CAPR
- Chrono
- Archives.-

Yaoundé, le 15 FEV 2012

REPUBLIQUE DU CAMEROUN
Republic of Cameroon
Paix - Travail - Patrie
Peace - Work - Fatherland
LE MINISTRE DE LA SANTE PUBLIQUE
MINISTER OF PUBLIC HEALTH

André MAMA FOUDA

5.8. Planning and monitoring of training activities

BURKINA FASO PLANIFICATION ET SUIVI DES ACTIVITES FORMATION ET EXPERTISE PROJET ESTHER. Dic 2012

Activité (Code)	Date de début et de fin de l'activité	Durée de l'activité en jour	Thème/Objectif de l'activité	Thème (code)	Nom du formateurs ou de l'expert	Profil Formateurs ou Experts (Code)	Structure de rattachement de l'intervenant	Nombre de jours travaillés	Origine du formateur ou de l'expert (Code)	Nombre de participants	Profil des participants (Code)	Structure de rattachement des participants	Commentaires
Atelier de formation	10 au 19 Avril	10	formation des acteurs et mise a jours de la base de données pediatrique	ESOPE	Equipe coordination	Autre	Coordination nationale ESTHER	**10**	Sud	**10**	Equipe pluridisciplinaire	**CHUP-CDG**	
Atelier de formation	7 au 10 Mai	4	formation des acteurs et mise a jours de la base de données pediatrique	ESOPE	Equipe coordination	Autre	Coordination nationale ESTHER	**4**	Sud	**10**	Equipe pluridisciplinaire	**CHUYO-Pediatrie**	
Assistance Technique	7 au 16 Mai	10	Evaluation HDJ Bobo	Différents thèmes traités	Oliver WEIL	Autre	Independant	**8**	Nord		Equipe pluridisciplinaire	**HDJ Bobo et autorités nationales**	**Consultant pour evaluation de l'HDJ sur financement MDP**
Assistance Technique	7 au 16 Mai	10	Evaluation HDJ Bobo	Différents thèmes traités	Charlotte DEZE	Autre	Independant	**8**	Nord		Equipe pluridisciplinaire	**HDJ Bobo et autorités nationales**	**Consultant pour evaluation de l'HDJ sur financement**
Conférence			conférence francophone AFRAVIH	VIH/IST					Nord		Médecin	**Coordination ESTHER**	
Atelier de formation	10-mai	1	« manifestations dermatologiques de l'infection à VIH »	PEC	Dr Traoré Fahima	Médecin clinicien	CHR OHG	1	Sud		Equipe pluridisciplinaire	CHR OHG	
Stage en France	03-27 Mai	24	ETP, Soins infirmiers	PEC	Dr Jacomet	Médecin clinicien	Clermont	21	Nord	1	Gynécologue	CHU YO	
Stage au Sud	21 mai- 02 juin	14	Réalisation CV par DBS	Biologie	Pr Sangare	Biologiste	CHU YO	14	Sud	2	Technicien de laboratoire	CHR OHG	
Stage au Sud	21 mai- 02 juin	7	PEC adulte de l'infection à VIH	PEC	Pr Drabo	Médecin clinicien	CHU YO	7	Sud	2	Médecin	CHR OHG	
Stage au Sud	28 mai-01 juin	5	PEC pédiatrique de l'infection à VIH	Pédiatrie	Pr Yé	Médecin clinicien	CHU PCDG	5	Sud	2	Infirmier	CHR OHG	
Compagnonnage	28 mai-02 juin	6	PEC pédiatrique de l'infection à VIH	Pédiatrie	Pr S Blanche	Médecin clinicien	CH Necker	6	Nord		Equipe pluridisciplinaire	CHU PCDG	
Compagnonnage	31 mai- 03 juin	3	Recherche Opérationnele	Recherche	Dr X Lescure	Médecin clinicien	Tenon	3	Nord		Equipe pluridisciplinaire	CHUSS Bobo	
Atelier de formation	11-15 juin	5	PEC pédiatrique de l'infection à VIH	PEC	Drs Nikiéma; Ouédr	Médecin clinicien	CHR OHG	5	Sud	15	Equipe pluridisciplinaire	CHR OHG	
Conférence	28-juin	1	Soins infirmiers et VIH	PEC	Kabore Salifou	Paramédicaux	CHR OHG	1	Sud		Equipe pluridisciplinaire	CHR OHG	
Atelier de formation	2-6 Juillet	5	PTME	PTME	Drs I Ouédraogo, D	Médecin clinicien	CHR OHG	5	Sud	20	pluridisciplinaire	CHR OHG	
Atelier de formation	13 au 17 Aout	5	formation des acteurs et mise a jours de la base de	ESOPE	Equipe coordination	Autre	Coordination nationale ESTHER	5	Sud	10	Equipe pluridisciplinaire	CM OASIS	

Stage au Sud	26/08-02/09	8		PEC	Dr Sawadogo	Médecin clinicien	CHUSS HDJ	7	Sud	4	pluridisciplinaire	CHU YO	
Formation universitaire	03/9-2/10	30	Recherche en santé de la reproduction et	Recherche	Dr Kouanda	Autre	IRSS	26	Sud	2	Médecin	CHU YO	Dr Kouanda est médecin de santé publique
Atelier de formation	10 au 15 septembre	6	formation des acteurs et mise a jours de la base de données pediatrique	ESOPE	Equipe coordination	Autre	Coordination nationale ESTHER	6	Sud	12	Equipe pluridisciplinaire	CMA Pissy	
Atelier de formation	23 Sept au 28	6	formation des acteurs et mise a jours de la base de données pediatrique	ESOPE	Equipe coordination	Autre	Coordination nationale ESTHER	6	Sud	12	Equipe pluridisciplinaire	CMA Pissy	
Assistance Technique	1 au 3 Aout	3	Supervision	PEC	Pr Drabo	Médecin clinicien	CHUYO	3	Sud	5	Equipe pluridisciplinaire	CMA Kombissiri	Infirmiers associés a l'equipe de formateurs
Assistance Technique	9 au 11 Aout	3	Supervision	PEC	Pr Drabo	Médecin clinicien	CHUYO	3	Sud	10	Equipe pluridisciplinaire	CHR Tenkodogo	Infirmiers associés a l'equipe de formateurs
Assistance Technique	14 au 16 Aout	3	Supervision	PEC	Pr Drabo	Médecin clinicien	CHUYO	3	Sud	8	Equipe pluridisciplinaire	CHR Ziniaré	Infirmiers associés a l'equipe de formateurs
Assistance Technique	6 au 8 Septembre	3	Supervision	PEC	Pr Drabo	Médecin clinicien	CHUYO	3	Sud	6	Equipe pluridisciplinaire	CMA Boussé	Infirmiers associés a l'equipe de formateurs
Atelier de formation	3-5 Octobre	3	PEC des principales I.O	Pédiatrie	Pr Yé	Médecin clinicien	CHU PCDG	3	Sud	30	Equipe pluridisciplinaire	CHU PCDG	
Stage au Sud	10/10- 10/11	30	formation Mycobacteriologie	Biologie			CHUN Cotonou					CHUSS Bobo	
Atelier de formation	15 au 01 novembre	14	formation des acteurs et mise a jours de la base de données pediatrique	ESOPE	Equipe coordination	Autre	Coordination nationale ESTHER	12	Sud	14	Equipe pluridisciplinaire	CHU-YO	
Stage au Sud	21/10-18/11	30	PEC Pédiatrique de l'infection à VIH	Pédiatrie			CHU Cotonou	27	Sud	1	Pédiatre	CHU PCDG	
Stage au Sud	21/10- 18/11	30	PEC psychologique	Pédiatrie		Psychologue	CHU Cotonou	27	Sud	1	Psychologue	CHU PCDG	
Compagnonnage	14-20 octobre	7	Atelier pays	Pédiatrie	Xavier	Autre	CHU Rouen	7	Nord		Equipe pluridisciplinaire	CHU PCDG	Profil: interne
Stage en France			Hygiène hospitalière	Hygiène hosp			CHU Montpellier		Nord			CHU SS	
Atelier de formation			PTME	PTME					Sud	15	Equipe pluridisciplinaire	MULTI site	Non réalisé CNP
Atelier de formation			ETP	ETP					Sud		pluridisciplinaire	MULTI site	Non réalisé CNP
Stage en France			gestion des 3e lignes	PEC		Médecin clinicien	Tenon		Nord	2	Médecin	CHUSS Bobo	Non réalisé
Assistance Technique		4	réalisation CV par DBS	Biologie	Pr Sangare	Biologiste	CHU YO	4	Sud		Technicien de laboratoire	CHR OHG	Non réalisé
Compagnonnage			projet pays	Biologie	Dr Anke B		CHU Montpellier		Nord			CHU SS	
Compagnonnage							Clermont						
Conférence	23-29/03	6	conférence francophone AFRAVIH	VIH/IST						2	Médecin	CHU YO,CNP	
Compagnonnage							Chambery		nord			CHR OHG	Non réalisé

Stage au Sud			ETP	ETP	Dr Sawadogo	Médecin clinicien	CHU SS/ HDJ		Sud		Infirmier	CHU YO	
Atelier de formation	2 au 5 Decembre	4	Améliorer et renforcer les dispositifs et l'efficacité du suivi/évaluation basés sur le logiciel ESOPE dans les pays partenaires d'ESTHER	ESOPE		Autre				6	Equipe pluridisciplinaire		
Autre	10 au 21 Decembre	12	Methode et outil de suivi evaluation de projets VIH	Gestion projet	Dr FOFANA	Autre	CAMPC	11	Sud	1	Médecin	CNP	
Atelier de formation	11 au 13 Decembre	3	seminaire régional	Pédiatrie		Médecin clinicien		3		5	Pédiatre	CHUYO,CHUPCDG,CMA Pissy,CHUSS	
Stage en France	janv-13	28	PEC pédiatrique de l'infection à VIH	Pédiatrie	Pr Blanche	Médecin clinicien	CHU Necker	28	Nord	1	Pédiatre	CHU PCDG	
Stage en France	15 au 24 decembre	10	Gestion administratives et financière	Gestion financière	Daffa Konaté	Administratif/Gestionnaire	GIP ESTHER	5	Nord	1	Administratif	CNP	

BURKINA FASO PLANIFICATION ET SUIVI DES ACTIVITES FORMATION ET EXPERTISE PROJET ESTHERAID Dic 2012													
Activités (Code)	**Date de début et de fin de l'activité**	**Durée de l'activité en jour**	**Thème/Objectif de l'intervention**	**Thème (code)**	**Nom de l'expert ou du formateur**	**Profil Formateurs ou Experts (Code)**	**Structure de rattachement de l'intervenant**	**Nombre de jours travaillés**	**Origine de l'expert ou du formateur (Code)**	**Nombre de participants**	**Profil participants (Code)**	**Structure de rattachement des participants**	**Commentaires**
Atelier de formation	6 au 11 Février	6	Formation des formateurs de l'HDJ Bobo en ETP	ETP	Catherine GREFFIER	Pédagogue	Format Santé	6	Nord	11	CPS	HDJ Bobo	
Assistance Technique	5 au 15 Février	8	Suivi des activités des associations partenaires	APS	Mesmin Dossou-Yovo	Autre	GIP ESTHER	8	Sud		Equipe pluridisciplinaire	Pluri	
Formation universitaire	06 février au 03 Mars	26	DIU Gestion des approvisionnements pharmaceutiques	Gestion dispensation ARV/IO		Autre	Université de Ouagadougou	22		7	Pharmacien	Sites ESTHERAID	
Assistance Technique	9 au 10 février	2	Atelier de concertation	APS	Mesmin Dossou-Yovo	Autre	GIP ESTHER	2	Sud	63	Equipe pluridisciplinaire		
Assistance Technique	18 au 24 février	7	Revitalisation des comités thérapeutiques	PEC	Larence SLAMA	Médecin clinicien	CHU Tenon	5	Nord	18	Equipe pluridisciplinaire	HDJ Bobo et les 7 sites EA	
Atelier de formation	18 au 24 février	7	Prise en charge des échecs thérapeutiques	PEC	Rob MURPHY	Médecin clinicien		5	Nord	18	Equipe pluridisciplinaire	HDJ Bobo et les 7 sites EA	
Assistance Technique	18 au 24 février	7	Mise en place d'un système de réalisation des charges virales	Biologie	Corrine Amiel	Biologiste	GIP ESTHER	5	Nord		Biologiste	HDJ Bobo	
Atelier de formation	18 au 24 février	7	Suivi de la mise en place des outils de l'éducation thérapeutiques des patients à l'HDJ Bobo	ETP	Françoise LINNARD	Médecin clinicien	CHU Tenon	5	Nord	5	Equipe pluridisciplinaire	HDJ Bobo et les 7 sites EA	
				ETP	Cecile MARECAT	Paramédicaux	CHU Tenon	5	Nord	5	Equipe pluridisciplinaire	HDJ Bobo et les 7 sites EA	
Autre	27 Fevrier au 3 Mars	6	Ellaboration de manuel de procedure de gestion des ARV et autres Intrants VIH	PEC	Pr J B NIKIEMA	Pharmacien	DGPML	6	Sud	10	Pharmacien	DGPLM,CMLS,DSME,	
Atelier de formation	26 au 31 mars	6	Formation et encodage des bases de données ESOPE	ESOPE	Dr Arsène HEMA	Médecin clinicien	HDJ Bobo	6	Sud	10	Equipe pluridisciplinaire	REVS+	Formation des acteurs sur ESOPE, mise à jour de la base, circuit du patient, archivage des dossiers patients
					Coodination nationale ESTHER Burkina	Médecin clinicien	ESTHER Burkina	6	Sud	10	Equipe pluridisciplinaire	REVS+	Formation des acteurs sur ESOPE, mise à jour de la base, circuit du patient, archivage des dossiers patients
Atelier de formation	2 au 3 avril	2	Formation et encodage des bases de données ESOPE	ESOPE	Dr Arsène HEMA	Médecin clinicien	HDJ Bobo	2	Sud	10	Equipe pluridisciplinaire	Do	Formation des acteurs sur ESOPE, mise à jour de la base, circuit du patient, archivage des dossiers patients
					Coodination nationale ESTHER Burkina	Médecin clinicien	ESTHER Burkina	2	Sud	10	Equipe pluridisciplinaire	Do	Formation des acteurs sur ESOPE, mise à jour de la base, circuit du patient, archivage des dossiers patients
Atelier de formation	4 au 5 avril	2	Formation et encodage des bases de données ESOPE	ESOPE	Dr Arsène HEMA	Médecin clinicien	HDJ Bobo	2	Sud	10	Equipe pluridisciplinaire	Espoir et Vie	Formation des acteurs sur ESOPE, mise à jour de la base, circuit du patient, archivage des dossiers patients
					Coodination nationale ESTHER Burkina	Médecin clinicien	ESTHER Burkina	2	Sud	10	Equipe pluridisciplinaire	Espoir et Vie	Formation des acteurs sur ESOPE, mise à jour de la base, circuit du patient, archivage des dossiers patients

Assistance Technique	6 Avril	1	Validation technique collecte des prélèvements, réalisation des charges virales et retour des résultats	Biologie	Dr Guillaume BADO	Biologiste	HDJ Bobo	1	Sud		Equipe pluridisciplinaire	Autorités nationales et partenaires des sites EA	
Assistance Technique	6 Avril	1	Validation technique collecte des prélèvements, réalisation des charges virales et retour des résultats	Biologie	Hermann SOMLARE	Biologiste	LNR VIH	1	Sud		Equipe pluridisciplinaire	Autorités nationales et partenaires des sites EA	
Atelier de formation	16 au 21 Avril	6	Formation des formateurs en accompagnement psychosocial et en relation d'aide	APS	Mamadou DIENG	Autre	GIP ESTHER	6	Nord	15	Equipe pluridisciplinaire	National	
Atelier de formation	15 au 22 Avril	6	Formation des formateurs en accompagnement psychosocial et en relation d'aide	APS	Mamadou TAPSOBA	Psychologue	GIP ESTHER	6	Nord	15	Equipe pluridisciplinaire	National	
Atelier de formation	23 au 25 avril 2012	3	Formation et encodage des bases de données ESOPE	ESOPE	Dr Arsène HEMA	Médecin clinicien	HDJ Bobo	3	Sud	10	Equipe pluridisciplinaire	CHR Gaoua	
Stage en France	18 mars au 01 avril	14	Pharmacovigilance	Autre	Dr Françoise HARAMBURU	Pharmacien	CHU Bordeaux	12	Nord	1	Pharmacien	DGPML	
Stage en France	18 Mars au 17 Avril	30	Pharmacovigilance	Autre	Dr Françoise HARAMBURU	Pharmacien	CHU Bordeaux	26	Nord	1	Pharmacien	DGPML	
Atelier de formation	23 au 25 avril 2012	3	Formation et encodage des bases de données ESOPE	ESOPE	Coodination nationale ESTHER Burkina	Médecin clinicien	ESTHER Burkina	3	Sud	10	Equipe pluridisciplinaire	CHR Gaoua	
Atelier de formation	26 au 28 avril	3	Formation et encodage des bases de données ESOPE	ESOPE	Dr Arsène HEMA	Médecin clinicien	HDJ Bobo	3	Sud	10	Equipe pluridisciplinaire	CHR Dédougou	
					Coodination nationale ESTHER Burkina	Médecin clinicien	ESTHER Burkina	3	Sud	10	Equipe pluridisciplinaire	CHR Dédougou	
Assistance Technique	1 au 13 Mai	13	Mission de suivi des activités APS et élaboration des outils de rapportage	APS	Mesmin DOSSOU-YOVO	Autre	GIP ESTHER	10	Sud				
Assistance Technique	21 au 26 Mai	6	Elaboration et finalisation du manuel de formation des conseillers psychosociaux (CPS)	APS	Mesmin DOSSOU-YOVO	Autre	GIP ESTHER	4	Sud	15	Equipe pluridisciplinaire	National	
Assistance Technique	27 Mai au 2 Juin	7	Formation des CPS en accompagnement psycosocial et en relation d'aide	APS	Mesmin DOSSOU-YOVO	Autre	GIP ESTHER	6	Sud	25	Equipe pluridisciplinaire	Associations partenaires sites ESTHERAID	
Formation universitaire	28 Mai au 23 Juin	27	DIU sur la pEC globale des PVVIH en Afrique francophone	VIH/IST			Université de Ouagadougou	23		3	Médecin	Sites ESTHERAID	
Atelier de formation	29 Mai au 2 Juin	5	Formation des CPS en accompagnement psycosocial et en relation d'aide	APS	Dr Daouda MARE	Médecin clinicien	REVS+	5	Sud	25	Equipe pluridisciplinaire	Associations partenaires sites ESTHERAID	
					Madina TRAORE	Psychologue	MASS	5	Sud	25	Equipe pluridisciplinaire	Associations partenaires sites ESTHERAID	
					Ramata DIALLO	Psychologue	HDJ Bobo	5	Sud	25	Equipe pluridisciplinaire	Associations partenaires sites ESTHERAID	
Assistance Technique	11 au 15 Juin	5	Evaluation de la mise à jour des bases de données des sites ESTHERAID	ESOPE	Célia BARBEROUSSE	Autre	GIP ESTHER	5	Nord		DATA	CHR Gaoua, Dédougou, CMA de Dafra, CM EV et REVS+	
Atelier de formation	09 au 13 juin	5	Formation des équipes de soins du CMA de Dafra et l'association EV en ETP	ETP	SOMBIE Diamasso	Paramédicaux	HDJ Bobo	5	Sud	13	Equipe pluridisciplinaire	CMA de Dafra, EV	8 infirmiers et 5 CPS
					POODA Gbolo	Paramédicaux	HDJ Bobo	5	Sud	13	Equipe pluridisciplinaire	CMA de Dafra, EV	8 infirmiers et 5 CPS

Atelier de formation	11 au 15 juin	5	Formation des équipes de soins du CHR de Dédougou en ETP	ETP	SANOU Yacinthe	Paramédicaux	HDJ Bobo	5	Sud	13	Equipe pluridisciplinaire	CHR de Dédougou	11 infirmiers et 2 CPS
					POODA Gbolo	Paramédicaux	HDJ Bobo	5	Sud	13	Equipe pluridisciplinaire	CHR de Dédougou	11 infirmiers et 2 CPS
Atelier de formation	18 au 22 juin	5	Formation des équipes de soins du CHR de Banfora en ETP	ETP	SOMBIE Diamasso	Paramédicaux	HDJ Bobo	5	Sud	10	Equipe pluridisciplinaire	CHR de Banfora	8 infirmiers et 2 CPS
					GUIBLA Ousséni	Paramédicaux	HDJ Bobo	5	Sud	10	Equipe pluridisciplinaire	CHR de Banfora	8 infirmiers et 2 CPS
Atelier de formation	25 au 29 juin	5	Formation des équipes de soins du CHR de Gaoua en ETP	ETP	SANOU Yacinthe	Paramédicaux	HDJ Bobo	5	Sud	10	Equipe pluridisciplinaire	CHR de Gaoua	7 infirmiers et 3 CPS
					BREUREC Yann	Paramédicaux	HDJ Bobo	5	Sud	10	Equipe pluridisciplinaire	CHR de Gaoua	7 infirmiers et 3 CPS
Atelier de formation	02 au 06 juillet	5	Développement des requêtes pour le calcul des indicateurs	ESOPE	Charif AFHO	Statisticien	PNLS Togo	5	Sud	1	Equipe pluridisciplinaire	ESTHER Burkina	
Atelier de formation	02 au 06 juillet	5	Formation des équipes de soins du CMA de Do et de l'association REVS+ en ETP	ETP	GUIBLA Ousséni	Paramédicaux	HDJ Bobo	5	Sud	11	Equipe pluridisciplinaire	CMA de Dô, REVS+	6 infirmiers, 5 CPS
					BREUREC Yann	Paramédicaux	HDJ Bobo	5	Sud	11	Equipe pluridisciplinaire	CMA de Dô, REVS+	6 infirmiers, 5 CPS
Atelier de formation	30 juillet au 03 août	5	Formation au protocole et au traitement des données de phamacovigilance	Gestion dispensation ARV/IO	Alassane BA	Pharmacien	CHMP	5	Nord	8	Pharmacien	DGPML, CMA de DO, CHUYO, CHUSS	
Assistance Technique	du 01 au 03 août	3	Validation des travaux de l'ATN sur la définition des modalités de fonctionnement des comité thérapeutiques et le plan de revitalisation des comités thérapeutiques existants	PEC	Dr Adrien SAWADOGO	Médecin clinicien	HDJ Bobo	3	Sud	35	Equipe pluridisciplinaire	Sites EA	
Assistance Technique	du 01 au 03 août	3	Validation des travaux de l'ATN sur la formalisation d'un dispositif de communication fonctionnelle entre l'HDJ Bobo et les sites périphériques du projet ESTHERAID	PEC	Dr Hervé HIEN	Médecin clinicien	Centre MURAZ de Bobo Dioulasso	3	Sud	35	Equipe pluridisciplinaire	Sites EA	
Assistance Technique	du 01 au 03 août	3	Validation des travaux de l'ATN sur la mise en plce d'un système de référence et contre référence entre l'HDJ Bobo et les sites périphériques du projet ESTHERAID	PEC	Dr Zézouma Philippe SANOU	Médecin clinicien	DSME	3	Sud	35	Equipe pluridisciplinaire	Sites EA	
Assistance Technique	du 01 au 03 août	3	Validation des travaux de l'ATN sur la mise en pace d'un système de rétroinformation entre l'HDJ de Bobo et les sites périphériques du projet ESTHERAID	PEC	Souleymane SIDIBE	Paramédicaux	Cabinet SERSAP	3	Sud	35	Equipe pluridisciplinaire	Sites EA	
Atelier de formation	29 au 31 Aout	3	Bonne pratiques de distribution des médicaments	Gestion dispensation ARV/IO	Dr Bassidou DEME	Pharmacien	DGPML	3	Sud	28	Equipe pluridisciplinaire	Sites EA	

Assistance Technique	11 au 15 septembre	5	Suivi de la mise en œuvre des supervisions formatives des sites périphériques et renforcement de compétences des superviseurs en pédagogie	Différents thèmes traités	Claudie PINOSA	Pédagogue	Format Santé	5	Nord	12	Equipe pluridisciplinaire	HDJ Bobo	Participants= Médecins, infirmiers, laborantins, préparateur en pharmacie
Atelier de formation	08 au 12 Octobre	5	1er Atelier de formation des chefs concepteurs pour l'élaboration d'outils pédagogiques pour l'éducation thérapeutique du patient vivant avec le VIH en Afrique Francophone.	ETP	Anne BEUGNY	Autre	GIP ESTHER	5	Nord	14	Equipe pluridisciplinaire	Activité transversale regoupant les participant des 5 pays ESTHERAID	Responsable Formations GIP ESTHER
					Elisabeth LIVOSLI	Autre	Indépendante	5	Nord	14	Equipe pluridisciplinaire	Activité transversale regoupant les participant des 5 pays ESTHERAID	Directrice arstistique
					Jacline IGUENANE	Pédagogue	Format Santé	5	Nord	14	Equipe pluridisciplinaire	Activité transversale regoupant les participant des 5 pays ESTHERAID	
					Adjim DANNGAR	Autre	Indépendant	5	Nord	14	Equipe pluridisciplinaire	Activité transversale regoupant les participant des 5 pays ESTHERAID	Illustrateur
Assistance Technique	22 au 24 octobre	3	Atelier de validation des travaux des ATN sur l'évaluation de la mise en œuvre du guide de bonne exécution des analyses de biologie médicale	Autre	Dr Yacouba DOMO	Pharmacien	DSME	3	Sud	37	Equipe pluridisciplinaire		
Assistance Technique	22 au 24 octobre	3	Atelier de validation des travaux de l'ATN sur l'évaluation du plateau technique de laboratoires pour le diagnostic de l'infection à VIH et le suivi biologique des PvVIH	Autre	Dr Yacouba DOMO	Pharmacien	DSME	3	Sud	37	Equipe pluridisciplinaire	Sites périphériques et niveau central	
Assistance Technique	22 au 24 octobre	3	Atelier de validation des travaux de l'ATN sur l'élaboration d'une stratégie régionale de maintenance des équipements biomédicaux	Autre	Dr Yacouba DOMO	Pharmacien	DSME	3	Sud	37	Equipe pluridisciplinaire	Sites périphériques et niveau central	
Assistance Technique	22 au 24 octobre	3	Atelier de validation des travaux de l'ATN sur l'élaboration de modules de gestion des intrants de laboratoire et des modules de formations relatifs	approvisionnement	Dr Charles Didier OUEDRAOGO	Pharmacien	DGPML	3	Sud	26	Equipe pluridisciplinaire	Sites périphériques et niveau central	
Atelier de formation	30 au 31 Octobre	2	Atelier de formation sur le système de collecte, de stockage et de transport des échantillons pour la réalisation de la charge virale	Biologie	Dr Guillaume BADO	Biologiste	HDJ Bobo	2	Sud	21	Equipe pluridisciplinaire	Sites ESTHERAID	
Atelier de formation	05 au 09 Novembre	5	Prise en charge globale des PVVIH	PEC	Dr Adrien SAWADOGO	Médecin clinicien	HDJ Bobo	5	Sud	15	Autre	Sites ESTHERAID	PEP et auxilliaires de pharmacie

Autre	5 Novembre au 7 Decembre	30	Infection à VIH et IST	PEC	?	Autre	IMEA	26	Nord	1	Infirmier	CMA DO	
Atelier de formation	05 au 10 novembre	6	1er atelier de formation des psychologues	APS	Nathalie NALLET	Psychologue	Indépendante	6	Nord	15	Equipe pluridisciplinaire	National	Psychologues, Infirmiers, conseillers psychosociaux…
Stage en France	05 novembre au 04 décembre	30	Stage au Centre Régional de Pharmacovigilance de Bordeau	Autre	Dr Françoise HARAMBURU	Pharmacien	Centre de Pharmacovigilance, Hopital Pellegrin-	22	Nord	1	Pharmacien	CHUSS	
Stage en France	17 novembre au 15 décembre	29	Stage au Centre Régional de Pharmacovigilance de Grenoble	Autre	Dr Céline VILLIER	Pharmacien	CRP du CHU de Grenoble	19	Nord	1	Pharmacien	DGPML	
Formation universitaire	5 Novembre au 7 Decembre	30	DIU Infection VIH et IST cours Fournier.	PEC		Autre	IMEA	26	Nord	1	Infirmier	CMA DO	
Atelier de formation	26 au 30 novembre	5	Prise en charge globale des PVVIH	PEC	Dr Adrien SAWADOGO	Médecin clinicien	HDJ Bobo	5	Sud	13	Autre	Sites ESTHERAID	PEP et auxilliaires de pharmacie
Atelier de formation	26 Novembre au 01 Décembre	6	2ème atelier de formation des psychologues	APS	Nathalie NALLET	Psychologue	Indépendante	6	Nord	15	Equipe pluridisciplinaire	National	Participants= Psychologues, Infirmiers, conseillers psychosociaux…
Atelier de formation	27 au 29 Novembre	3	Formation des acteurs et mise à jour base ESOPE	ESOPE	Coodination nationale ESTHER Burkina	Autre	ESTHER Burkina	3	Sud	10	Equipe pluridisciplinaire	CMA de Do	
Autre	10 au 14 Décembre	5	Formation à l'analyse des données avec STATA	Autre	Institut Pasteur	Statisticien	Institut pasteur	5	Nord	1	Médecin	HDJ Bobo	
Atelier de formation	12 au 14 Décembre	3	Prise en charge globale des PVVIH	PEC	Dr Adrien SAWADOGO	Médecin clinicien	HDJ Bobo	3	Sud	15	Equipe pluridisciplinaire	Sites ESTHERAID	Phamaciens et PEP et Auxillaires de pharmacie
Atelier de formation	17 au 18 Décembre	2	Formation au GBEA	Biologie	Dr NIKIEMA Abdoulaye	Biologiste	DGPML	2	Sud	26	Biologiste	Sites ESTHERAID	Participants: pharmaciens biologistes et technologistes biomédicaux
Atelier de formation	17 au 22 Décembre	6	Formation des acteurs et mise à jour base ESOPE	ESOPE	Coodination nationale ESTHER Burkina	Autre	ESTHER Burkina	6	Sud	10	Equipe pluridisciplinaire	CHR Banfora	
Atelier de formation	19 au 21 Décembre	3	Formation à la gestion des intrants du laboratoire	Biologie	Dr NIKIEMA Abdoulaye	Biologiste	DGPML	3	Sud	26	Biologiste	Sites ESTHERAID	Participants: pharmaciens biologistes et technologistes

CAM PLANIFICATION ET SUIVI DES ACTIVITES FORMATION ET EXPERTISE PROJET ESTHER. Nov 12.													
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Compagnonnage	13-20 janvier 12	8	ATELIER DE RENFORCEMENT DES CAPACITES DES MEMBRES DES CTAS ET UPEC SOUS L'EGIDE DU CHU DE NANCY	Infections Opportunistes	Pr Christian Rabaud, Infectiologue : c.rabaud@chu-nancy.fr	Médecin clinicien	CHU NANCY	3	Nord	20	Equipe pluridisciplinaire	CTA HR GAROUA et UPEC	
				AES	Laurence Rol : Cadre de santé : l.rol@chu-nancy.fr	Paramédicaux	CHU NANCY	3	Nord	20	Equipe pluridisciplinaire	CTA HR GAROUA et UPEC	
				PEC	Pr Christian Rabaud, Infectiologue : c.rabaud@chu-nancy.fr	Médecin clinicien	CHU NANCY	3	Nord	20	Equipe pluridisciplinaire	CTA HR GAROUA et UPEC	
				Counseling	Marie Laure Abdelkader, Psychologue : ml.abdelkader@chu-nancy.fr	Psychologue	CHU NANCY	3	Nord	20	Equipe pluridisciplinaire	CTA HR GAROUA et UPEC	
				ESOPE	Dr BESSALA Dorothée, référente ESOPE	Médecin clinicien	CTA HR GAROUA	3	Sud	20	Equipe pluridisciplinaire	CTA HR GAROUA et UPEC	
				Hygiène hosp	Laurence Rol : Cadre de santé : l.rol@chu-nancy.fr	Paramédicaux	CHU NANCY	3	Nord	20	Equipe pluridisciplinaire	CTA HR GAROUA et UPEC	
				Observance	Marie Laure Abdelkader, Psychologue : ml.abdelkader@chu-nancy.fr	Psychologue	CHU NANCY	3	Nord	20	Equipe pluridisciplinaire	CTA HR GAROUA et UPEC	
Atelier de formation	16-20 janvier	5	formation ESOPE	ESOPE	BOUBA BASSIROU	Autre	ESTHER	5	Sud	20	Médecin	CTA BAFOUSSAM, LIMBE, HGD HLD, BAMENDA	
					Dr NGANG PETER	Médecin clinicien	CHE	5	Sud	20	Opérateur de saisie		
					DIBOG LUC	Data Manager	DLM	5	Sud	20	Data Manager		
Compagnonnage	20-24 février	5	suivi et supervision du tutorat	Différents thèmes traités	David REY	Médecin clinicien	HUS STRASBOURG	5	Nord	15	Equipe pluridisciplinaire	HGD, SAKBAYEME, BONASSAMA	
Compagnonnage	19-25 février 2012	7	suivi et supervision des activités CTA et UPEC	Différents thèmes traités	Dr. David REY,	Médecin clinicien	Responsable Médical du Trait d'Union, H.U.S.	5	Nord	10	Equipe pluridisciplinaire	CTA HGD, UPEC de Bonassama et Sakbayeme	
Compagnonnage	17-21 avril 12	5	prise de contact entre les deux équipes	APS	Dr Marialuisa PARTISANI, Mme Isabelle GALLAND,								
Atelier de formation	17-21 avril 12	5	PEC des effets secondaires des ARV	Observance	Dr Marialuisa PARTISANI	Médecin clinicien	HUS STRASBOURG	1	Nord	29	Equipe pluridisciplinaire	HR EBOLOWA, UPEC, CSI	
				APS	Mme Isabelle GALLAND,	Psychologue	HUS STRASBOURG	2,5	Nord	29	Equipe pluridisciplinaire	HR EBOLOWA, UPEC, CSI	
Atelier de formation	16-21 avril 12	6	renforcement des capacités	AES	Dr KENGNE	Médecin clinicien	HR GAROUA	4	Sud		Equipe pluridisciplinaire	UPEC TOUBORO	
				Counseling									
				ETP									
				Infections Opportunistes									
				PTME									
				Tuberculose									

Atelier de formation	4-8juin	5	renforcement des capacités sur la PECG	PTME			ESTHER HAMBOURG	5	Nord	76	Equipe pluridisciplinaire	35 SITES DU NORTH WEST	
				Hygiène hosp			ESTHER HAMBOURG	5	Nord	34		17 SITES DU NORTH WEST	
Atelier de formation		3	renforcement des capacités sur la PECG	Différents thèmes traités	BARLA	Médecin clinicien	HG DOUALA	3	Sud	14	Equipe pluridisciplinaire	SAKBAYEME	
Stage au Sud	18-22 juin	3	renforcement des capacités sur la PECG	Différents thèmes traités	Dr BO'ORO	Médecin clinicien	HR MAROUA	3	Sud	6	Equipe pluridisciplinaire	CTA HR MAROUA	
Atelier de formation	3-6 juillet2012	3	PEC global proche des normes standard et aux directives nationales.	Différents thèmes traités	non spécifié dans le rapport	non spécifié dans le rapport	HR GAROUA	3	Sud	non spécifié	Equipe pluridisciplinaire	UPEC DE POLI	absence d'appareil de mesure de CD4
Atelier de formation	24-27 juillet	3	renforcement des capacités sur la PECG	Différents thèmes traités	ATANGA Léonel	Médecin clinicien	CTA EBOLOWA	3	Sud	15	Equipe pluridisciplinaire	UPEC AMBAM	3 médecins, 7 infirmiers, 3 AS, 1 techn labo
				Différents thèmes traités	NGUEND FILS	Biologiste	CTA EBOLOWA	3	Sud	15	Equipe pluridisciplinaire	UPEC AMBAM	
Atelier de formation	10-13 juillet	3	renforcement des capacités sur la PECG	Différents thèmes traités	ATANGA Léonel	Médecin clinicien	CTA EBOLOWA	3	Sud	14	Equipe pluridisciplinaire	UPEC SANGMELIMA	3 médecins, 6 infirmiers, 4 ARC, 1 techn labo
				Différents thèmes traités	NGUEND FILS	Biologiste	CTA EBOLOWA	3	Sud		Equipe pluridisciplinaire	UPEC SANGMELIMA	
Atelier de formation	7-10 août	3	renforcement des capacités sur la PECG	Différents thèmes traités	ATANGA Léonel	Médecin clinicien	CTA EBOLOWA	3	Sud	14	Equipe pluridisciplinaire	UPEC DE LOLODORF	7 infirmiers, 2 ARC, 3 ASG, 2 technicien labo
				Différents thèmes traités	NGUEND FILS	Biologiste	CTA EBOLOWA	3	Sud		Equipe pluridisciplinaire	UPEC DE LOLODORF	
Stage au Sud	27-31 août	5	pratique	Différents thèmes traités	ATANGA Léonel	Médecin clinicien	CTA EBOLOWA	5	Sud	4	Equipe pluridisciplinaire	UPEC de SANGMELIME et ZOETELE	3ARC +1 IDE
	3-7 septembre	5	pratique	Différents thèmes traités	ATANGA Léonel	Médecin clinicien	CTA EBOLOWA	5	Sud	4	Equipe pluridisciplinaire	UPEC DE LOLODORF Et AMBAM	2 infirmiers, 1 AS et 1 statisticien

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Formation universitaire	06 février au 03 mars 2012		Gestion des approvisionnements	approvisionnement	Equipe DUI Pharma de Ouaga	Pharmacien	Université de Ouaga + ESTHER	30 jours	Sud & Nord	2	Pharmacien	CENAME, CAPR	Formation diplomante DIU de Ouagadougou
Atelier de formation	31-mai-12	1jour	Coordination régionales des approvisionnements en intrants VIH	approvisionnement	Rose NGONO MBALLA	Pharmacien	ATN/ESTHER	3 jours	Sud	15	Equipe pluridisciplinaire	DRSP & CAPR Ouest, CTA Bafoussam, UPEC, CNLS, DPM	PDK y a pris part
Atelier de formation	07-juin-12	1jour	Coordination régionales des approvisionnements en intrants VIH	approvisionnement	Rose NGONO MBALLA	Pharmacien	ATN/ESTHER	2jours	Sud	17	Equipe pluridisciplinaire	DRSP & CAPR Sud, CTA Ebolowa, UPEC, CNLS, DPM	
Atelier de formation	15-juin-12	1jour	Coordination régionales des approvisionnements en intrants VIH	approvisionnement	Rose NGONO MBALLA	Pharmacien	ATN/ESTHER	2jours	Sud	16	Equipe pluridisciplinaire	DRSP & CAPR Littoral, CTA HGD & CTA HLD, UPEC, CNLS, DPM	
Atelier de formation	26-juin-12	1jour	Coordination régionales des approvisionnements en intrants VIH	approvisionnement	Rose NGONO MBALLA	Pharmacien	ATN/ESTHER	2jours	Sud	17	Equipe pluridisciplinaire	DRSP & CAPR Sud Ouest, CTA Limbè, UPEC, CNLS, DPM	
Atelier de formation	28-juin-12	1jour	Coordination régionales des approvisionnements en intrants VIH	approvisionnement	Rose NGONO MBALLA	Pharmacien	ATN/ESTHER	2jours	Sud	11	Equipe pluridisciplinaire	DRSP & CAPR Nord Ouest, CTA Bamenda, UPEC, CNLS, DPM	
Atelier de formation	02-juil-12	1jour	Coordination régionales des approvisionnements en intrants VIH	approvisionnement	Rose NGONO MBALLA	Pharmacien	ATN/ESTHER	3jours	Sud	16	Equipe pluridisciplinaire	DRSP & CAPR Extrême Nord, CTA Maroua, UPEC, CNLS, DPM	
Atelier de formation	04-juil-12	1jour	Coordination régionales des approvisionnements en intrants VIH	approvisionnement	Rose NGONO MBALLA	Pharmacien	ATN/ESTHER	2jours	Sud	11	Equipe pluridisciplinaire	DRSP & CAPR Adamaoua, CTA Ngaoundéré, UPEC, CNLS, DPM	
Atelier de formation	06-juil-12	1jour	Coordination régionales des approvisionnements en intrants VIH	approvisionnement	Rose NGONO MBALLA	Pharmacien	ATN/ESTHER	2jours	Sud	11	Equipe pluridisciplinaire	DRSP & CAPR Nord, CTA Garoua, UPEC, CNLS, DPM	
Atelier de formation	10-juil-12	1jour	Coordination régionales des approvisionnements en intrants VIH	approvisionnement	Rose NGONO MBALLA	Pharmacien	ATN/ESTHER	2jours	Sud	12	Equipe pluridisciplinaire	DRSP & CAPR Est, CTA Bertoua, UPEC, CNLS, DPM	
Atelier de formation	24-juil-12	1jour	Coordination régionales des approvisionnements en intrants VIH	approvisionnement	Rose NGONO MBALLA	Pharmacien	ATN/ESTHER	3 jours	Sud	25	Equipe pluridisciplinaire	DRSP & CAPR Centre, CTA HGY, CHE, HGOPY & HCY, UPEC, CNLS, DPM	
Atelier de formation	25 - 26 septembre 2012	2 jours	Gestion des approvisionnements	approvisionnement		Pharmacien	DPM, CNLS	02 jours	Sud	25	Equipe pluridisciplinaire	CENAME,CAPR, CTA, UPEC, CNLS	
Formation universitaire	01 au 31 octobre 2012	30 jours	Rétrovirologie	Biologie	Pr S Mboup & Pr L Belec	Autre	Université de Dakar	30 jours	Sud & Nord	3	Biologiste	CTA	Formation diplomante DIU de Rétrovirologie de Dakar
Atelier de formation	25 au 27 octobre 2012	3 jours	PECP	Pédiatrie	Catherine DOLLFUS, Sidonie LYEB et Rose M KONGO	Autre	TROUSSEAU, CHE, HLD	03 jours	Sud & Nord	37	Equipe pluridisciplinaire	CTA, UPEC	
Atelier de formation	29 au 31 octobre 2012	3 jours	PECP	Pédiatrie	Catherine DOLLFUS & Rose M KONGO	Autre	TROUSSEAU, HLD	03 jours	Sud & Nord	18	Equipe pluridisciplinaire	CTA, UPEC	
Atelier de formation	07 au 09 novembe 2012	3 jours	PECP	Pédiatrie	Nadine TROCME & Ida PENDA C	Autre	TROUSSEAU, HLD	3 jours	Sud & Nord	43	Equipe pluridisciplinaire	CTA, UPEC	

RCA PLANIFICATION ET SUIVI DES ACTIVITES FORMATION ET EXPERTISE PROJET ESTHER. Sept 2012

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Stage en France	11 au 20 Janv	9	Impregnation sur les procédures ESTHER	Gestion financière			GIP ESTHER	4	Nord	1	Administratif	Coordination ESTHER RCA	
Atelier de formation	25 janv au 02 Fev	7	Formation en AES/ HH	AES	Bruno ABRAHAM	Médecin clinicien	Hop Brive	5	Nord	20	Equipe pluridisciplinaire	CNHUB, HCB, CNRIST/TAR, CPB, HOP AMITIE	
					Georgette EYMARD	Paramédicaux	Hop Brive	5	Nord				
Atelier de formation	8 au 13 Fevrier	5	Atélier de formation sur la PEC des populations vulnérables	Autre	Mamadou Dieng	Autre	GIP ESTHER	3	Nord	25	Equipe pluridisciplinaire	CNHUB, HCB, CNRIST/TAR, associatifs, Min santé, min justice, min des Affaires	
					BELEC	Biologiste	HEGP	3	Nord				
Stage en France	18 Fev au 9 mars	21	Stage en Hygiene des soins	Hygiène hosp			CHU d'Amiens	18	Nord	1	Infirmier	HCB	
Assistance Technique	9 au 23 Fev	14	document GAS de la phase 2 du R7 et du	approvisionnement	Vincent HAMEL	Pharmacien	Independant	12	Nord				
Assistance Technique	14 au 30 Mars	16	du document GAS de la phase 2 du R7 et du MTF	approvisionnement	Vincent HAMEL	Pharmacien	Independant	14	Nord				
Conférence	22 au 31 Mars	9	AFRAVIH Geneve	thèmes traités			OMS	4		4	Médecin	ESTHER, CNHUB, CPB, HCB	
Stage en France	11 au 31 Mai 2012	22	Echange d'expériences sur la PEC des PVVIH	PEC			CHU d'Amiens	17	Nord	1	Médecin	CNRIST/TAR	
Formation universitaire	26 Mai au 25 Juin	28	Participation de médecins prescripteurs et/ou	PEC			DIU de Ouaga	25		1	Médecin	CNHUB	
Atelier de formation	30 Mai au 07 Juin	7	Formation en hygiene hospitalière	Hygiène hosp	DEGOUY Patrick	Paramédicaux	CHU d'Amiens	5	Nord	29	Equipe pluridisciplinaire	HCB	
					Helene	Paramédicaux	CHU d'Amiens	5	Nord				
Compagnonnage	6 au 13 Juin 2012	7	Suivi et supervision des CPS	APS	Monia Lambert	Autre	RESSY	5	Nord	20	Conseiller psycho-social ou médiateur	CNRIST/TAR, CNHUB, HCB, CPB	
Compagnonnage	20 au 28 Juin	7	Suivi implémentation de la charge virale au LNR	Biologie	BELEC Laurent	Biologiste	HEGP	5	Nord	4	Equipe pluridisciplinaire	LNR	
Atelier de formation	12 au 20 Sept	7	Formation de l'équipe de recherche sur les populations vulnérables sur la méthode qualitative et l'approche genre	Recherche	Christine Salomon	Psychologue	Inserm	6	Nord	18	Equipe pluridisciplinaire		
Formation universitaire	21 au 30 Sept	9	Formation à la prise en charge des populations vulnérables à Lomé	Autre			RAF VIH	5		3	Equipe pluridisciplinaire		

RCA PLANIFICATION ET SUIVI DES ACTIVITES FORMATION ET EXPERTISE PROJET ESTHERAID. Sept 2012													
Activités (Code)	**Date de début et de fin de l'activité**	**Durée de l'activité en jour**	**Thème/Objectif de l'intervention**	**Thème (code)**	**Nom de l'expert ou du formateur**	**Profil Formateurs ou Experts (Code)**	**Structure de rattachement de l'intervenant**	**Nombre de jours travaillés**	**Origine de l'expert ou du formateur (Code)**	**Nombre de participants**	**Profil participants (Code)**	**Structure de rattachement des participants**	**Commentaires**
Assistance Technique	26 Janv au 22 Fev	27	Elaborer une stratégie de decentralisation de la PECP	Pédiatrie	Laurent AVENTIN	Autre	Independant	21	Nord				
					Anne N'JOM LEND	Médecin clinicien	Independant	21	Sud				
Formation universitaire	6 Fevrier au 3 mars	28	diplomante à la gestion des intrants pharmaceutiques	approvisionnement				23		3	Pharmacien	UCM, CNLS	
Atelier de formation	22 Fev au 1er mars	7	ETP pédiatrique et transfert des adolescents	ETP	Genevieve VAUDRE	Paramédicaux	TROUSSEAU	5	Nord	25	Equipe pluridisciplinaire	CPB, HCB, CNHUB	
Assistance Technique	7 au 22 Mars	15	l'organisation du système de stockage, de	approvisionnement	CANN Jean Michel	Pharmacien	AEDES	12	Nord				
					CHORLIER Christian	Pharmacien	AEDES	12	Nord				
Atelier de formation	5 au 12 Mai	7	Formation des formateurs en relation d'aide	APS	Mamadou DIENG	Psychologue	GIP ESTHER	5	Nord	16	Equipe pluridisciplinaire	CTA/CRF; CNHUB, DGLS, CPB, HCB,	
					Mohamed TOURE	Autre	GIP ESTHER	5	Sud				
Formation universitaire	26 mai au 25 Juin	28	Participation de médecins prescripteurs et/ou d'infirmiers	Différents thèmes traités			DIU de Ouaga	24		2	Médecin	CPB, BOY RABE	
Compagnonnage	19 au 23 Juin	4	Mise en place d'un service minimun de prise en charge pédiatrique	PEC	Pierre FRANGE	Médecin clinicien	CHU NECKER	4	Nord	6	Médecin	CPB	
Conférence	11 au 15 Juin	4	systèmes nationaux d'approvisionneme	approvisionnement			OMS	4		2	Pharmacien	CNLS; UCM	
Stage en France	18 Juin au 8 Juillet	22	des compétence en assurance qualité	approvisionnement			CHMP	21		1	Pharmacien	DPM	
Compagnonnage	11 au 19 Juillet	7	Suivi de la formation en ETP PED	ETP	Genevieve VAUDRE	Paramédicaux	TROUSSEAU	5	Nord	25	Equipe pluridisciplinaire	CPB	
Atelier de formation	25 Juillet au 5 Aout	7	Formation des sages femmes et assistantes	APS	Mamadou Dieng	Autre	GIP ESTHER	5	Nord	22	Equipe pluridisciplinaire	CPB, HCB, HA, CHI, CASTORS, boy rabe,	
					Mohamed TOURE	Autre	GIP ESTHER	5	Sud				
Atelier de formation	30 Aout au 5 Sept	7	Formation des formateurs nationaux	ETP	Arlette Communier	Paramédicaux	FORMASANTE	5	Nord	9	Equipe pluridisciplinaire	CPB, CTA/CRF, CNRIST/TAR, CNHUB	

MALI PLANIFICATION ET SUIVI DES ACTIVITES FORMATION ET EXPERTISE PROJET ESTHER. Nov 12												
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Atelier de formation	13 au 14 Fév 2012	2	Protocole de recherche biomédicale portant sur un médicament à usage humain	Recherche	Roland Tubiana	Médecin clinicien	LPS	2	Nord	35	Equipe pluridisciplinaire	CESAC Bko,CHU Point G,CHU Gabriel Touré,SEREFO,USAC CV et CI	
		2			Lambert Assoumou	Statisticien	LPS	2	Nord				
		2			Christine Katlama	Médecin clinicien	LPS	2	Nord				

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DIU	06 Février au 03 Mars	27	DIU pharmacie de Ouaga: la gestion pharmaceutique	Gestion dispensation ARV/IO	Multiples formateurs	Autre	Diverses	23	Sud	3	Pharmacien	USAC CNAM de Bamako, CHR de Mopti et le CHU du point G	les formateurs viennent en majorité de la sous région, quelque uns de la France
Autre	28 fevrier au 02 Mars	4	Suivi projets pays, en partuclier programmation ESTHERAID Mali	Gestion projet	Pierre Mendiharat	Autre	GIP ESTHER	4	Nord	4	Equipe pluridisciplinaire	coordination ESTHER Mali	
DIU	28 Mai au 23 juin 2012	27	DIU ouaga prise en charge VIH	Différents thèmes traités	Multiples formateurs	Autre	Diverses	24	Sud	3	Equipe pluridisciplinaire	CESAC de Bamako, CHU du point G et CHR de Kayes.	les formateurs viennent en majorité de la sous région, quelque uns de la France
Atelier de formation	17 au 21 Sep 2012	5	Formation des réferents et superviseurs nationaux sur les modules de base et avancé du logiciel ESOPE	ESOPE	Bouba BASSIROU	Médecin clinicien	Departement médical ESTHER	5	Sud	15	Equipe pluridisciplinaire	CSLS/MS,DRS Kayes,Kkro,Sko,Ségou,Mopti,Bko,CHU Point G,Csréf CII,CHU Gabriel T,CNAM,Esther Mali	
Atelier de formation	08 au 12 Oct 2012	5	Outils pédagogiques pour l'ETP adulte enfant: organisation du 1er atelier régional octobre 2012 Ouagadougou	ETP	Anne Beugny/Format Santé	Pédagogue	GIP ESTHER	5	Nord	5	Equipe pluridisciplinaire	Diverses	
Atelier de formation	15 au 16 Oct 2012	2	Formation sur les méthodologies (pédagogie) de formation ESOPE	ESOPE	Ousmane B Touré	staticien	CSLS/MS	2	Sud	3	Equipe pluridisciplinaire	DRS(kayes, segou, Bamako)	
Atelier de formation	18 au 20 Octobre 2012	3	Formation des Opérateurs de saisies ESOPE	ESOPE	Ousmane B Touré	staticien	CSLS/MS	3	Sud	21	Equipe pluridisciplinaire	Bamako(CHU Point G, CHU GT, CESAC , USAC (1,4,5,CNAM) Mopti(CESAC et Hopital) , Segou(Wallé et Hopital), Sikasso(CERKES, Hopital et koutiala),Kayes(Hopital de Kayes)	
DIU	1 Octobre au 31 Octobre 2012	31 jours	DIU retrovirogie de DAKAR	Biologie	Formateur du DIU de Dakar	Pharmacien	Faculté de Médecine, de Pharmacie et d'odontostomatologie de Bamako	20	Sud	1	Biologiste	Laboratoire SEREFO/faculté de médecine	
Autre	30 Oct au 02 Nov 2012	4	Evaluation à mi parcour du Projet ESTHERAID à DOUALA	Différents thèmes traités	Direction GIP Paris	Autre	ESTHER MALI	4		3	Equipe pluridisciplinaire	Coordination ESTHER	
Atelier de formation	06 au 08 Nov.	3	Conception des outils ETP	ETP	Chefs concepteurs	pluridisciplinaire	ARCAD/SIDA	3	Sud	13	Equipe pluridisciplinaire		

Exemple de remplissage du tableau de suivi de la formation et de l'expertise												
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Atelier de formation	12 au 14 mars 2012	3	PEC mère-enfant. Résistance 2ème ligne	Pédiatrie	Arthur Alacaron	Médecin clinicien	CHU Necker	3	Nord	10	Equipe pluridisciplinaire	Complexe Pédiatrique de Bangui
					Bénédicte Dumas	Biologiste	CHU Necker	3	Nord			
Compagnonnage	15 au 16 mars 2012	2	organisation et gestion de la prise en charge pédiatrique	Pédiatrie	Arthur Alacaron	Médecin clinicien	CHU Necker	2	Nord	3	Pédiatre	Complexe Pédiatrique de Bangui
Compagnonnage	15 au 16 mars 2012	2	organisation et gestion de la prise en charge pédiatrique	Pédiatrie	Bénédicte Dumas	Biologiste	CHU Necker	2	Nord	2	Biologiste	
Atelier de formation	19 au 22 juin 2012	4	Formation à la construction d'outils pédagogique ETP	ETP	Elizabeth Dupont	Pédagogue	CHU Avignon	4	Nord	20	Associatif	Association pour la lutte contre le SIDA
					Jean Bonnet	Pédagogue	Ministère de la Santé publique du Cameroun	4	Sud			
					Anne Beugny	Autre	GIP ESTHER	3	Nord			
Atelier de formation	2 au 5 juillet 2012	4	Formation/ recyclage aux bonnes pratiques de stockage et de distribution des intrants	Pédiatrie	Paul Chick	Pharmacien	AEDES	4	Nord	12	Pharmacien	DGPLM/ CAME
Stage en France	10 au 21 juillet	12	Former à la technique de PCR	Biologie			CH Bichat	9			Technicien de laboratoire	Laboratoire National de Bamako
Assistance Technique	25 aout au 8 septembre 2012	15	Définir le circuit d'acheminement et de retour de résultats entre les services (par site)	Biologie	Roberto Weiss	Biologiste	CHU Tenon	11	Nord			

Formation universitaire	6 au 10 septembre 2012	5	Participation de médecins prescripteurs et/ou d'infirmiers impliqués au DIU VIH de Ouagadougou	Différents thèmes traités			DU Ouaga	5		15	Equipe pluridisciplinaire	Hopital Central de Yaoundé/ Centre Mère et Enfant N'djamena/Hopital Général Gabriel Touré/ Complexe Pédiatrique de Bangui
Conférence	18 au 20 septembre 2012	3	Prise en Charge Pédiatrique	Pédiatrie			GIP ESTHER			3	Pédiatre	Hopital Central de Yaoundé
Stage au Sud	30 septembre au 6 octobre 2012	7	Stages de formation pratique en maintenance des equipements biomédicaux	Biologie			CHU Treichville	5		2	Biologiste	HDJ BOBO
Atelier de formation	17 au 19 octobre 2012	3	Mise en place du logiciel ESOPE au niveau des sites de prise en charge	Suivi Eval	Célia Barberousse	Autre	GIP ESTHER	3	Nord	3	Opérateur de saisie	CHU Cotonou

EncodageThèmes	
AES	AES
AGR	AGR
APS	APS
Biologie	BIO
Counseling	COUN
Dermatologie	DERM
Usage drogue	DRO
ESOPE	ESO
ETP	ETP
Suivi Eval	EVAL
approvisionnement	GAS
Gestion financière	GEF
Gestion projet	GEP
Hygiène hosp	HAES
Hépatites	HEP
Infections Opportunistes	IO
VIH/IST	IST
Différents thèmes traités	MULTI
Nutrition	NUT
Observance	OBS
Parasitologie	PARA
PEC	PEC
Gestion dispensation ARV/IO	PHA
Pédiatrie	PED
PTME	PTME
Recherche	RECH
Tuberculose	TB
Autre	

Encodage Activité		
Atelier de formation	AF	AF = ateliers de formation sur site, national ou régional
Compagnonnage	COM	
Formation universitaire	DIU	
Stage en France	STF	
Stage au Sud	STS	
e-learning	EL	
Conférence	CONF	
Assistance Technique	AT	AT= missions d'évaluation, d'appui à des process, rédaction de guide lines, projets
Autre		

Encodage profil participants	
Agent de relais communautaire	AC
Administratif	ADM
Agents pénitentiaire	AP
Assistant social	AS
Aide soignant	ASOI
Associatif	ASSO
Auxilliaire	AUX
Biologiste	BIO
Conseiller psycho-social ou médiateur	CPS
Data Manager	DATA
Dispensateur	DISP
Gestionnaire	GEST
Gynécologue	GYN
Infirmier	INF
Informaticien	ING
Ingénieur	INGE
Technicien de laboratoire	LAB
Médecin	MED
Opérateur de saisie	OS
Pair Educateur	PE
Pédiatre	PED
Pharmacien	PHA
Equipe pluridisciplinaire	PLURI
Pneumologue	PNEUMO
Psychologue	PSY
Sage femme	SF
Statisticiens	STAT
Usagers de drogue	UD
Autre	

Encodage profil formateurs ou experts	
Biologiste	BIO
Data Manager	DATA
Administratif/Gestionnaire	GEST
Informaticien	ING
Médecin clinicien	MED
Paramédicaux	PARAM
Pédagogue	PEDA
Pharmacien	PHA
Psychologue	PSY
Statisticien	STAT
Autre	

Origine de l'expert ou du formateur
Nord
Sud