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Evaluation of the Medicines Transparency Alliance Phase 1 2008-2010

Summary Report

Elizabeth Ollier

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Contents

Abbreviations

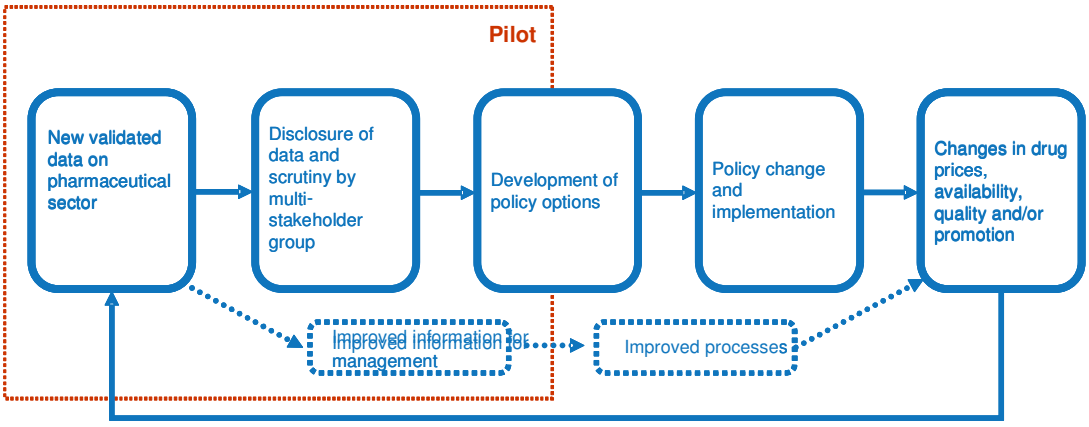
AtM	Access to Medicines
CSO	Civil society Organisations
DFID	Department for International Development
DOS	Department of Statistics (Jordan)
EC	European Community
EFO	Externally Funded Output
ED	Executive Director
EITI	Extractive Industries Transparency Initiative
EMP	Essential Medicines and Pharmaceutical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

Background

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

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

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



The current Medicines Transparency Alliance is formed of DFID, the World Bank and WHO working in partnership with the pilot countries. The World Bank also had high level commitment to and expertise on work in governance, on which the MeTA could draw. WHO had undertaken much of the predecessor work and had a considerable interest and expertise. In addition they managed complementary programmes such as the Good Governance for Medicines Programme (GGM).

The Evaluation

The evaluation of the MeTA initiative took place between 1st December 2009 and 28th Feb 2010. The MeTA initiative is dynamic and iterative change is constant (it is

anticipated that significant new information will be available and discussed in MeTA countries from later spring) but this report does not include events or changes after 28th February 2010.

None of the evaluation team members had worked with MeTA previously. They visited five countries, Ghana, Jordan, Philippines, Uganda and Zambia. In addition, telephone interviews were undertaken in respect of evaluations of the work in Peru and Kyrgyzstan. Considerable background literature was made available which also informed the process. Every effort was made to triangulate information to achieve accuracy. All country reports were shared with the country Chairs and coordinators who verified factual content. In addition to country level interviews and documentation, the team leader also attended a number of international events and conducted face to face and telephone interviews. All international consultants had the opportunity to read and comment on the main report and it was additionally subject to the HDRC's quality assurance procedures.

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

- Countries can establish functioning multi-stakeholder groups to agree plans for the generation and disclosure of robust policy relevant information on the price, quality, availability and/or promotion of medicines.
- MeTA can build capacity to and result in the disclosure and scrutiny of relevant and high-quality information on the price, quality, availability and/or promotion of medicines
- MeTA can facilitate the development of informed proposals for changes in policy and business practices.

Establishing a Framework for MeTA in pilot countries

Gaining Government Commitment and establishing multi stakeholder councils

A pre requisite for involvement in MeTA was a commitment from governments of participating countries. All seven MeTA pilot countries have now established multi stakeholder groups (Councils) and have agreed workplans which include proposals to generate and disclose information relating to price, quality, availability and promotion of medicines. This is, in itself, a major success. Not all Councils have equal involvement from all three sectors and this can partially be explained by variations in the strength of the sectors. Thus the private sector in Kyrgyzstan is disbursed and finds collective representation of the sector difficult. In Jordan, the civil society sector is in early stages of development. However, in all countries there is regular multi-sectoral attendance at Council meetings.

Sectoral involvement in MeTA councils by country

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

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

Governance frameworks for country level multi sectoral bodies vary and not all yet conform wholly with international best practice.

Establishing National MeTA Secretariats

In country secretariats vary in size, location and capacity. There is a need to identify what competences are required and to design the secretariats accordingly. Location of the Secretariat may in some cases have significant advantages but also has the potential to compromise independence. The solution arrived at in the Philippines appears to be positive where the Secretariat will shortly be housed in WHO. It is believed that this will encourage greater engagement with the MOH. Likewise, there are many advantages in MeTA being located in the High Health Council in Jordan though the office manages to retain a distinctive identity with clear MeTA branding. However the location of the Zambia Secretariat in the offices of a major NGO may affect external perceptions of its independence.

If new countries adopt the MeTA principles and create Secretariats, it is suggested that stronger guidance is provided on the:

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

- Need to agree limits of delegation and authority.

Supporting National Capacity Building

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

A number of regional and international courses have been held. In general, these have been well received and fulfilled a dual role in increasing skills and knowledge but also increasing trust and engagement. Participants also value lesson learning from other countries and solidarity created when comparing successes/challenges. The Harvard Pharmaceutical Policy Flagship course[1] was particularly successful although ideally it should have been available earlier in the MeTA establishment process.

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

Workplans

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

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

A message was received in some countries that workplans should aim for “low hanging fruit.” Whilst the need for demonstrable quick wins is understandable (e.g. as a way to build trust among stakeholders), this has resulted in MeTA being an alternative funding stream for existing activities in Uganda (and possibly other countries).

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

Harmonisation

MeTA is unusual for a DFID funded programme in that it has been set up across a

[1] The Pharmaceutical Policy Flagship course was developed by Harvard School of Public Health with DFID funding (separate to MeTA funding) and is based on the World Bank Flagship Course on Health Systems. The course was run for the first time in Jordan in February 2010.

number of countries and outside normal country planning processes. There is a real issue about whether MeTA complies with Paris Principles given that not all workplan activities appear to be reflected in MOH planning processes.

Where senior public sector managers are involved with MeTA, synchrony appears improved. In Jordan, the chair of MeTA is Secretary to the High Health Council. For the first time the recently published the National Health Accounts refer to medicines issues. A major conclusion of the NHA as a whole has been: "*An effective strategy of cost containment, to include greater use of utilization review mechanisms and the implementation of an effective prescription drug policy, should be of highest priority*". This indicates that the issue of rational use of medicines has achieved high profile.

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

Delivering against the MeTA Objectives in countries

Progress towards Data Identification

MeTA has both used tools from predecessor initiatives and developed new tools. In each country a significant body of information exists, some of it generated from predecessor or complementary programmes. **Annex 1** summarises information available in each country at the time of the evaluation. Many countries initially focussed on information relating to the prices in the chain. However, there is an increasing recognition of the value of other information. MeTA is designed to focus on four aspects (quality, price, promotion and access). Given that price is likely to be a contentious issue among constituencies, there may be greater mutual benefit in also identifying key information which is indicative of the other three aspects first to establish trust (e.g. information to users about how to recognise counterfeits, incidence of stock outs and which good quality medicines are registered in country).

In Ghana, there is a recognition of the potential value of information from the National Health Insurance Agency. Its database is primarily designed to assess claims but contains information about prescribing that does not follow the guidelines for rational use. This is important because insurance reimbursements for drug costs are escalating – from about 7% of NHIA expenditures in 2005 through 39% in 2007 to an estimated 55% in 2009. Problems include widespread non-adherence to the approved medicines list, spurious claims and irrational prescribing.

Progress towards Disclosure

Countries have all completed a disclosure survey which identifies what information (both regarding policies and procedures and data) is publicly available. This survey has the potential to help Councils identify ownership of information, priorities for disclosure and existing gaps. All seven countries have now undertaken a disclosure survey but it appears that there are variations in quality and completeness. Councils and secretariats

were encouraged to complete this survey themselves. Some have viewed this as a substantial body of work that was difficult to manage given the voluntary participation of Council members. However, others have found the tool as a useful way to bring the different constituencies together to work on a specific task. In Jordan, the council sat together to complete the exercise and described it as eye-opening. By looking together at websites, some practical issues of data availability became apparent. Sometimes data was available, but was difficult to find on a website; the practical difference between "disclosure" and "accessible to the individual citizen" became apparent.

Progress towards changes in policy and business practice

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

So far, no changes have been identified in business practice. Whilst the private sector is involved in each country forum, there is a feeling in some countries that their involvement is driven by a wish to achieve particular business results (e.g. changes in tax application etc). Whilst there is no identification of disclosure which gives mutual benefit (win: win) there is a danger that all parties are not benefiting equally from discussion. MeTA Councils should ensure the goal of increasing access to quality, affordable medicines continues to guide their work.

Progress towards Logframe Purpose Level Objectives

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

The Genesis of MeTA

Building on predecessor work and working with current initiatives

MeTA builds strongly on the Regional Collaboration for Action on Essential Drugs in Africa Programme, which ran 2002 – 2009, with DFID funding. It has used the survey tools developed in this programme and learnt lessons relating to the creation of National Professional Officers in national WHO offices to provide support. MeTA has synergy with the WHO Good Governance for Medicines programme but the level of collaboration with GGM both nationally and internationally, is variable.

Design, tender and contract

MeTA built on the principles of preceding work including EITI. The design work incorporated much consultation and scoping but was lengthy. The very diverse selection of countries and the number of countries chosen was probably ambitious for a pilot phase. Given the range of national languages more resources were desirable for

translation and interpretation. There are lessons to be learnt from the contracting process.

International Governance

Establishing the MeTA Alliance

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

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

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

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

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

MeTA Management Board (MMB)

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

International Advisory Group (IAG)

The role of IAG has not been sufficiently clear. The advice required from the IAG and how this should be communicated to Alliance members and countries needs to be reviewed. There is huge potential and expertise in the membership, which has remained untapped. Despite the time given by and good will of members, the lack of a clear remit

and failure to capitalise on the expertise of the membership have meant that the IAG has, in its current form, provided poor value for money.

International MeTA Secretariat (IMS)

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

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

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

Engaging with the Private Sector

There has been much contact with major international manufacturers who have expressed interest in the MeTA concept. However, none had been prepared to commit at the time of the evaluation (although discussions were ongoing). This may be because there is still not a clear message being articulated about what they are being asked to commit to. The private sector at country level is very diverse (e.g. manufacturers, importers, wholesalers and a variety of retailers) and varies considerably across countries. Private sector surveys have been conducted in a number countries to identify key stakeholders. However, participation has been variable across the range of private sector stakeholders and across MeTA countries.

Engagement with Civil Society

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

Communications

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

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

Technical Assistance

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

Partner support WHO

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

Partner support World Bank (WB)

The level of commitment to MMB and IAG has been considerable. However, variable engagement by task team leaders for countries has meant that Bank expenditure at country level has been limited and uneven (although effective where there has been activity, such as in Jordan and Ghana).

Are the MeTA Hypotheses Proven?

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

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

Currently, evidence is weakest for the value of the contribution of the private sector to the aims of MeTA at international and country levels. There are indications of the potential for their involvement in the multi-stakeholder process, but actual outputs in terms of information sharing are lacking. Given the diversity of the private sector at country level, and the potential for information sharing to challenge existing business models (particularly for distributors and retailers), it is perhaps not surprising that engagement has been tentative at these early stages.

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

The difficulties in establishing the infrastructure and agreeing the workplans has undoubtedly prolonged and consumed considerable national time and effort. Work planning processes could have been more efficient if great guidance had been available to countries on core components for MeTA, better sequencing of activities (e.g. undertaking the disclosure survey before drafting a work plan) and with increased support from the IMS and TA. The problems, where they exist, do not appear to be so much to do with the principles than with the implementation.

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

Looking to the Future

DFID indicated at the creation of MeTA that, should the pilot phase prove successful and new funders were interested, then a further tranche of funding was available to continue for a total of ten years (i.e. until 2018). There are a number of big questions, as follow, which will need to be considered if MeTA 2 is agreed.

Funding mechanisms and identification of new funders

DFID is currently exploring the possibility of identifying additional funders, in the event of MeTA proceeding beyond the pilot stage. If this is to be successful, it is important that there is an agreed, consistent message being disseminated by all current members of the Alliance, as to;

- The MeTA model and value proposition? (i.e. MeTA's unique and particular contribution)
- Potential benefits at country and international levels
- The incentives for all the key stakeholders at country and international levels
- How will success be measured?

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

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

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

Governance arrangements

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

The MeTA Management Board needs to separate oversight from operational involvement and be clear about the respective roles of the Alliance partners and the executive (Secretariat).

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

At country level, stronger guidance could be provided on the constitution of the multi-stakeholder Forum/ council and model job descriptions for Secretariat staff, proforma reports etc. This would allow current councils to all meet a basic standard of good governance and would enable new countries to get running faster. There would be no requirement to use the model but it would provide a template.

Identification of new countries

Undertaking the pilot in seven countries was extremely ambitious particularly given their geographic spread which increased support costs and made country to country contact more difficult. If MeTA continues beyond the current pilot, then serious consideration will need to be given to how realistic it would be to have a tranche of new countries coming on board. It might be worth considering a second tranche of countries all being in geographical proximity to reduce support costs and encourage mutual support and learning. They could be supported on a south:south basis by one of the existing countries.

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

- The government and MOH having a proven attitude to transparency and a willingness to put information into the public arena which holds them to account
- The pharmacy division of the MOH able to engage and not already committed to a major DP funded project which allows little time for other initiatives (as is currently the case in Uganda)
- Other complementary work identifying information already being in place and willing to work collaboratively (GGM/ HAI etc)
- Local representatives of DFID, WHO, the WB and any other partners being enthusiastically supportive and prepared to “open doors”
- A private sector organised in such a way that it can have representatives of all aspects of private sector activity (i.e. one or more associations who can represent manufacture, import, wholesale, distribution, retail and private sector prescribing)
- A strong CSO sector with the potential to work together
- Consideration needs to be given to whether it is realistic to work with a country where English is not the first language. Support material is currently in English and there is no current budget for translation. Both the WB and WHO have this capacity however and if translation were possible into (say) French, Spanish, Russian and Arabic it would widen the potential pool of countries.

Whether to continue support to existing countries

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

The design and identification of the international secretariat function

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

- It is a single collocated organisation preferably with a track record of delivering multi country programmes
- It has both demonstrable expertise and networks for supporting programmes in the field of medicines
- It can provide a professional manager to lead the programme with experience in managing international programmes of this size and complexity
- It has already developed finance, performance management and monitoring systems suited to the contract type (e.g. service and fee).

What might be different?

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

It is therefore suggested that there is an understanding established from the beginning that countries are signing up to an approach which incorporates established proven approaches and good practice. By adopting MeTA principles, countries are buying into a model which is based on experience. Participating in MeTA should entail commitment to complete a core set of activities (such as baseline data collection and civil society capacity building). Clearly, counties may, over time, decide to vary the model to adapt to local circumstances and augment these core activities.

The pilot phase was not able to sequence activities in a sensible order. This was due, in part, to the initial design of the programme and preliminary scoping work not including or providing a baseline and to some of the tools that have proved useful not being available

at the outset.

Learning from this experience it is suggested that key events might be delivered in a different order

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

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

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

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

In summary, considerable progress has been made in a relatively short period of time. The purpose level objectives have been achieved and the model shows signs of validity. It is too early to realistically expect changes to policy and business practice but there are promising signs. However the form of future programme implementation needs to be restructured to maximise efficiency and effectiveness.

Annex 1. Survey Information available as of 28.02.10

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

	Prescribing survey (design agreed)	MeTA/ WHO	Ongoing	No
	Pricing survey	WHO/HAI	2005	Available only in English and not used by nationals
	Disclosure survey	MeTA	2010	No
Peru	Peruvian Medicines Price Observatory	MOH/ WHO/ HAI	2007	Scheduled
	Pharmaceutical Assessment	???	2006	??
	Disclosure survey (not in standard format)	MeTA	2010	No
Philippines	Level 2 Facility and household Surveys	MOH/WHO/MeTA	Ongoing	No (initial results of survey to council Aug 2009)
	Survey of components of Medicine Prices	HAI/ WHO/ DOH/	??	Yes, on HAI website
	Civil society mapping survey	CSOs	2009	Yes amongst CSOs
	Bench Book (standards for accrediting facilities)	PHIC/WHO/MeTA	2009	Yes with pilot facilities
	Study of Public Procurement Prices	MeTA/WB	ongoing	No
	Disclosure survey	MeTA	2009	No
Uganda	Medicine Pricing surveys	MOH/HAI/WHO (08) MOH/MeTA (09)	2008 ongoing	Yes No
	Household survey	WHO/MeTA	2009	Yes
	Facility survey	WHO	2008	Yes
	Communication materials on RUM	WHO/MeTA	2009	Yes but associated activities not started
	NDA registration information	MeTA/NDA	2009	Yes online but not updated and price and quality not yet included
	Disclosure survey	MeTA	2010	No
	Private Sector Mapping	MeTA	2009	Discussed within META
Zambia	Assessment of procurement and supply management systems (draft)	MOH/WHO	2009	No
	Good governance for medicines	WHO	2008	No
	Mapping of partners in procurement and supply management of essential medicines and supplies	MOH/WHO	2007	No

	(draft)			
	Pharmaceutical sector baseline survey	MOH/WHO	2006	No
	List of registered medicines	MRA	2009	Yes
	Disclosure survey (draft)	MeTA	2010	No
	Private Sector Mapping	MeTA	2009	Discussed within META

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