Medicines Transparency Alliance
A review of the pilot
## Contents

1. **Medicines Transparency Alliance – a pilot project**  
   The challenge ................................................. 3  
   The hypothesis .................................................. 4  
   The policy .......................................................... 4  
   The project .......................................................... 5

2. **Medicines Transparency Alliance – the structure**  
   The pilot countries .............................................. 8  
   International support and activities ......................... 9

3. **Creating a multi-stakeholder alliance**  
   The stakeholders ................................................. 11  
   The dialogue ...................................................... 13  
   Leadership and co-ordination ................................ 15

4. **Generating evidence**  
   MeTA baseline assessments .................................. 17  
   Sharing information ............................................. 18  
   Accountability .................................................... 20

5. **Translating evidence into policy and practice**  
   Achievements ..................................................... 23

6. **Conclusions** .................................................. 30
Medicines Transparency Alliance – a pilot project

The Medicines Transparency Alliance (MeTA) began life as a hypothesis. This hypothesis became a policy. This policy became a project. This project has become – in two and a half years and in seven countries across the globe – a unique and exciting force for change.

This document will track this evolution. It will look at the way in which the Medicines Transparency Alliance has developed in seven very different countries – Ghana, Jordan, Kyrgyzstan, Peru, Philippines, Uganda and Zambia. It will reflect on the challenges faced and the progress that has been made. It will note specific achievements and highlight the important lessons that have been learned over the course of the pilot, which can be used to inform future projects.

The challenge

Across the globe, one person in every three (about two billion people), lacks access to essential medicines. Every year, millions of people die from illnesses such as malaria, pneumonia, cardiovascular disease and diarrhoea. Millions more struggle to live with conditions such as diabetes, high blood pressure and mental illness. For these people, often the poorest, the essential medicines which can be used to cure or manage their illnesses can be too expensive, counterfeit or sub-standard, wrongly prescribed or out of stock in their health centres.

The complexity of the pharmaceutical market and a lack of information (or conflicting information) about the medicines supply chains are at the root of these problems. In countries where there is no up-to-date, validated information on the price, quality, availability and promotion of medicines, competition is distorted, corrupt practices are allowed to flourish and medicines are used irrationally. Without this information it is difficult, if not impossible, to identify where the accountability lies and therefore how the problems should be tackled, and by whom.

“Up to 90 per cent of the population in developing countries purchase medicines through out-of-pocket payments. Medicines account for the second greatest household expenditure, right behind food.”

Dr Margaret Chan, Director General, World Health Organization, July 2010
The hypothesis

The MeTA hypothesis goes as follows: getting information about the medicine supply chain out in the open and having it analysed and discussed by three major stakeholder groups – the government, private sector and civil society – will lead to a better understanding of the problems, greater incentives to pioneer change and greater responsibility and accountability upon those needed to instigate these changes. The anticipated result is increased access to medicines for the most vulnerable sectors of society.

Transparency is not a new concept. Indeed the combination of transparency and multi-stakeholder groups was not an original notion and a similar project in the area of mining was already underway. But applying these models to the area of medicines and health policy was a bold and unique innovation, partly because pharmaceutical supply chains are extremely complex with a multitude of players and transactions.

The policy

In 2008, the United Kingdom’s Department for International Development (DFID) turned this hypothesis into policy. This was, in part, as a response to the United Nation’s Millennium Development Goals (MDGs) and MDG 8.e in particular.

The Medicines Transparency Alliance is exactly what it says it is. It is about medicines – getting them to the people who need them. It is about transparency – getting the information about these medicines and their supply chains out in the open. It is about alliance – getting all the relevant stakeholders together so that they can understand this information and work together to change detrimental policies and activities. Above all it is about making ground in the global effort to make more essential medicines accessible to the people who, often desperately, need them.

The Millennium Development Goals, to be achieved by 2015, were adopted by 189 world leaders and signify an international commitment to reduce poverty and hunger, and to tackle ill-health, gender inequality, lack of education, lack of access to clean water and environmental degradation.

Millennium Development Goal 8.e “In cooperation with pharmaceutical companies, provide access to affordable essential medicines in developing countries” deals directly with increasing access to essential medicines. It recognises that health is a fundamental human right and that access to healthcare, including access to essential medicines, is a prerequisite for realising that right. It also recognises that achieving the MDGs will require a partnership of governments, the private sector and civil society.
The project

The decision then came to start the MeTA project. The approach was bold and novel. It aimed to redraw the landscape of the pharmaceutical market – changing policies, behaviour and the balance of power. A pilot phase was therefore required to test the hypothesis, design and implement the new approaches and tools, and to assess whether MeTA could be viable in increasing access to medicines over the long-term.

With the support of the World Bank (WB) and the World Health Organization (WHO), whose long-standing experience, knowledge and reputation in this field would be vital in bringing the project to life, DFID invited seven countries to run this ambitious pilot.

The seven pilot countries – Ghana, Jordan, Kyrgyzstan, Peru, Philippines, Uganda and Zambia – were chosen as places where access to medicines was limited but where there was also a willingness to address this problem. They are clearly very different countries. Not only are they a diverse group in terms of language and culture, but their health policies, civic structures, funding mechanisms and the challenges they face also vary considerably. This diversity ensured that the MeTA model would be rigorously tested.

This also meant that MeTA developed at different rates and in different ways in each country – in response to respective political and social contexts. Indeed, the countries, while members of a ‘global alliance’ which could offer them support, guidance and a sense of ‘community’, were encouraged to shape their structures, priorities and work programmes within existing frameworks to ensure the project would be country-led and as sound and sustainable as possible.

“By 2015, an estimated 10.5 million lives could be saved every year by expanding access to existing treatment for infectious diseases, maternal and child health and non-communicable diseases.”

World Health Organization
This document will chart the experiences of the countries by the phases which all the countries went through, from inception to where they are now. The key phases are:

- **Creating a multi-stakeholder alliance** – bringing together representatives from the three stakeholder groups – the government, private sector and civil society

- **Generating evidence** – collecting, sharing and analysing the data to get a clear picture of the policies and practices that affect the accessibility of essential medicines and understand the changes needed

- **Translating evidence into policy and practice** – using this data to set priorities and agree clear, measurable goals and the strategies for achieving them to improve access to essential medicines.

Over the course of the pilot, the countries themselves have found the exchange of experiences, challenges, achievements and ideas invaluable in the development of their programmes. As a consequence, there is a wealth of shared experience and information to draw on. This document will use this information, not to provide a blueprint for future projects but to provide a realistic account of the overall MeTA experience and a solid basis from which these projects can develop.

“MeTA has brought us together with people we used to be suspicious of – the government and regulators. For me, as a businessman, transparency regarding tendering, pricing and registration of products enables us to plan properly. It has been very beneficial.”

**John Allotey,**
**Director of LaGray Pharmaceuticals Ltd., Ghana**
In order to consider the way in which MeTA has developed and functioned in the pilot countries it is useful to understand the way in which the project has been structured.

**International MeTA Secretariat (IMS)**

The IMS was established to coordinate, organise, promote and support the implementation of MeTA at all levels. It has channelled technical and financial support to the pilot countries, whilst maintaining contact with all national stakeholders, strengthening capacity, organising global and regional meetings of working groups to facilitate cross-country learning, and servicing the global governance structures.

**MeTA Management Board (MMB)**

Chaired by DFID, the MMB has been the core group of the founding partners – DFID, WHO and the World Bank. The MeTA Management Board has provided overall guidance for the programme and has agreed the support provided to participating countries through the IMS.

**International Advisory Group (IAG)**

The International Advisory Group has supported the overall work of MeTA with a particular commitment to its transparency and accountability goals. It consisted of elected representatives from each pilot country and a number of experts drawn from international organisations, academia and the private sector.
The pilot countries

The ways in which MeTA was established and the rate at which certain elements of the programme progressed have varied from country to country. However, a number of fundamental elements have been established in every country.

**Country Forums, MeTA Councils and Secretariats**

**MeTA Forum:** Each of the pilot countries has organised a national multi-stakeholder forum. The MeTA Forum, which has met twice a year, consists of a wide representation of all stakeholders and other parties interested in access to essential medicines and transparency issues.

**MeTA Council:** The national MeTA Councils represent the high-level multi-stakeholder groups which have governed the MeTA process in each country, have met regularly and have overseen the implementation of the MeTA programme. They have facilitated the debate on national issues and priorities and every MeTA Council has formulated and begun to implement a work programme.

The make-up of these Councils has not been uniform across the pilot countries but they have all included the principal senior public, private sector and civil society actors. Membership is voluntary (unpaid) and has been drawn from a combination of representatives from:

- **Government** – Ministry of Health, Drug Regulatory Authority, National Procurement Agency, National Health Insurance body
- **Business** – domestic manufacturers, generic and brand-name pharmaceutical companies, importers, wholesalers and retailers
- **Professional groups** – doctors, nurses and pharmacists
- **Civil society** – community, patient, health, consumer, good governance and transparency groups, media, faith-based organisations
- **Academics**
- **Development partners**

**MeTA Secretariat:** The development and implementation of each country’s work programme has been coordinated by a national secretariat (which usually has one or two paid individuals), which has reported to the MeTA Council and has been supported by the IMS.
International support and activity

The International MeTA Secretariat has provided direct country support and has worked closely with the national secretariats on their distinct technical and coalition-building issues. It has also provided a number of international services and resources, and facilitates the global exchange of ideas, advice and support.

Tools

Over the course of the pilot a series of ‘tools’ have been designed, implemented and adapted to aid the development of MeTA. Some have been specifically designed for the programme and others have been adopted from existing tools offered by organisations such as WHO, the World Bank, Health Action International and the Harvard School of Public Health. Each tool covers a particular area of work and they range from guidance on creating a multi-stakeholder alliance to household surveys that identify how medicines are used by patients and the availability and accessibility of medicines in a specific region.

International and national forums

The International MeTA Secretariat sought to create a continuous flow of information, ideas, experience and best practice between the pilot countries and with the rest of the global health community. A number of national and international meetings and events were organised to expedite this exchange.

These included:
• MeTA Country Sharing – a three day meeting with representatives of the seven countries to share successes, challenges and lessons learned (December 2009)
• Pharmaceutical Policy Reform – a Flagship Course developed by the Harvard School of Public Health and supported by the World Bank and MeTA (Jordan, January 2010)
• Multi-Stakeholder Working – a two-day workshop on the experience and challenges of multi-stakeholder working, facilitated by Wageningen University (Jordan, January 2010)
• Civil Society Capacity Strengthening – multi-country CSO capacity building workshops were held in Philippines (June 2008) for Philippines, Jordan, Kyrgyzstan and Peru and another workshop was held in Uganda for Ghana, Uganda and Zambia (February 2008).
• MeTA Learning Exchange Visits – the pilot countries learned from each other through learning visits. Jordan and Zambia visited Philippines (April 2010) and Uganda, Jordan and Philippines visited Ghana (June 2010)
• Capacity Building Workshops on Governance – these were held in collaboration with the Construction Sector Transparency Initiative (CoST) in Tanzania (May 2010 – MeTA Uganda attended), in Zambia (May 2010) and Ghana (June 2010)
• Global MeTA Forum – a five-day meeting with representatives of all stakeholders from all countries to share experiences and lessons learned (June 2010).
Creating a multi-stakeholder alliance

“MeTA has brought about capacity building in the civil society sector which is now able to articulate the issues in the medicines supply chain.”

Goodwell Lungu, Director of Transparency International Zambia

One of the most fundamental elements of MeTA in each of the pilot countries has been the creation of the national MeTA Councils as multi-stakeholder groups. These have developed into the most dynamic, unpredictable and crucial (and, some would say, the most successful) elements of the programme.

All seven pilot countries have had an active multi-stakeholder MeTA Council made up of representatives from the government, private sector and civil society. The make-up of the Council has varied in each country but this new platform for discussion and decision-making has been described as a ‘leap forward’ in building trust and confidence, bringing out technical knowledge and allowing the planning and development of country policies to happen in a more open and effective way.

The creation of this new group dynamic took time and patience, but it has led to a greater understanding between these stakeholders. Former adversaries have had the opportunity to get to know each other, listen to each other’s challenges and find common interests. Taking these perspectives into account, they have been able to discuss issues and agree priorities and goals that work for all three parties and, most importantly, for patients. This has led to greater trust, responsibility and accountability for the decisions made and the aims agreed by the group. It has also redressed the balance of power in the supply chain – tipping it more towards the consumer who, for example, can see whether there has been an excessive mark-up on the price of a particular medicine at some point between its manufacture and its sale.

The MeTA Council has performed a slightly different function in each of the countries. For example, in Kyrgyzstan, MeTA filled a vital gap in a politically unstable environment. In Zambia, unethical practices in the Ministry of Health had led to a great deal of mistrust and MeTA has been able to sit independently of government and create a space where the private and CSOs ‘found each other’ and began a positive and unique dialogue – in which the government ultimately joined. In Philippines and Uganda, MeTA has created a ‘safe space’ where the stakeholders, who would normally be critical of each other, could talk openly and constructively.
The stakeholders

It was vital that all three stakeholder groups were actively engaged in each MeTA Council. The government of each country had a key role to play as the policy-maker and the provider of health care and medicines. The private sector, as the manufacturer, importer, distributor and retailer of medicines, was also pivotal. The civil society groups were similarly crucial – as the ‘voice of the people’ and as the organisations who really understood the impact that a lack of access to essential medicines has on the lives of patients and their families (for example, going without food or education to pay for medicines). As one participant said, “CSOs keep it real”. However, engaging each of these groups in the alliance was not straightforward.

Government: Some governments are understandably reluctant to address allegations of corruption or inefficiency – particularly in what would effectively be a public forum with representatives from ‘activist’ groups. Individual officials find it difficult to speak out, for fear of being ‘named and blamed’. Advocacy can be threatening to some governments – particularly in countries where civil society groups do not have a prominent or ‘institutionalised’ position in the countries’ decision-making processes.

Private sector: The private sector, which consists of health providers, prescribers, manufacturers, importers, wholesalers, distributors and retailers, is the prime actor in the essential medicines supply chain in many countries. As much as 80 per cent of all essential medicines are sold within the private market. Weaknesses in the supply chain can impact very heavily on the price, quality, and availability of medicines. However, for some private sector organisations there was a reluctance to become involved in an unfamiliar forum where they felt they might be expected to disclose commercially sensitive information. Understandably, any activity that might put them at a competitive disadvantage or expose them to commercial risk was viewed with suspicion.

Civil Society: For CSOs, the incentives for engagement in the MeTA project were more obvious. In many cases they were being offered a seat at the table in an area where they had previously found themselves on the margins. But this in itself presented a number of problems. In a few of the pilot countries, where the civil society sector had not yet been effectively mobilised, their capacity and resources were low and they found themselves as the ‘weaker’ partner. In other countries there were many highly-mobilised CSOs, but their sheer volume often meant they were fragmented and were unable to present a united and coordinated voice. Across the board, many of the CSOs – having spent so long shouting from the sidelines – found it difficult, at first, to engage with the other stakeholders in a structured dialogue.

The challenge for the development partners was to find a way of framing the goals of the project in terms that each of the stakeholders could understand and relate to. It was clear that vested interests needed to be vocalised – ‘on the table’ – so that each stakeholder could understand and appreciate the others’ motives and the conversation could move beyond partiality. Indeed, through this process a number of preconceptions were discarded and personal relationships started to develop.

The development partners worked hard through their existing networks, relationships and reputations to support the participation of the three stakeholder groups.
They worked with the private sector, outlining incentives for engagement, including:

- Building relationships with government where they did not previously exist
- Dispelling myths about corporate malpractice
- Highlighting where access to data might help them understand their markets better.

They also worked in some of the pilot countries to build the capacity and the skills of the CSOs so that they could engage with the other parties on an equal footing. This included:

- Training on technical aspects of medicines and guidance on communications – both in terms of high level ‘lobbying’ and community campaigns
- Advising on how to play an effective part in a coalition – in terms of honing diplomacy and negotiation techniques.

It is interesting to note that work in the area of HIV/AIDS has already led in some of the pilot countries to a more sophisticated and effective CSO lobby and many of the skills (and indeed personnel) have successfully transferred across to the MeTA programme. Likewise, the skills and capacity built during the MeTA pilot are transferable to other sectors and programmes.

Lessons from the pilot:

- Conduct a rigorous mapping of the key stakeholders and the existing political and social context – this will give a better insight which will lead to more sophisticated and diplomatic approaches to guidance and direction.
- Build MeTA into existing structures and cultures as far as possible – at the very least there needs to be a mechanism which effectively links the Council to the country’s decision-making processes.
- Identify incentives and constraints – undertake an early and dispassionate participatory assessment
- Gauge the situation of the stakeholders – what are they interested in tackling? And how? How can their motives be aligned?
- Create a level playing field – provide resources to facilitate the participation of those who would not normally be able to join in and to build their skills to play an effective role in the partnership.
The dialogue

The real benefit of the creation of the multi-stakeholder groups is the ‘dialogue’. The shared space that MeTA has created in each of the pilot countries is invaluable. The opportunity to hear others’ experiences means that the stakeholders have learned things they did not know before and this has resulted in a more sophisticated grasp of the issues and constraints that other participants face. The fact that they have acknowledged this information and have shown such a willingness to listen has been a powerful step in itself. For many it has been revelatory. Steps as simple as taking an industry person to a clinic (on the basis of a new and trusting relationship) to see firsthand the difficulties being faced by the health workers and patients in getting hold of the necessary medicines have been monumental in changing hearts, minds and policies.

Another key aspect is the fact that the process of working together, for example, when collecting, analysing or validating the baseline research data, has been instrumental in building solid and trusting relationships.

What has also come out of this process is that different aspects of the dialogue do not always require the same group of people and that there is an argument for ‘layering’ the multi-stakeholder groups. For example, when there were large groups of participants, discussion of an issue became generic and not sufficiently focused on the specific problem or solution facing the pilot country. Smaller working groups or sub-committees would be able to achieve greater depth of discussion if they specifically included those who really understand a topic or have access to and can interpret the sometimes dense, technical or sensitive information.

Lessons from the pilot:

• The Council should be made up of a wide group of individuals who discuss broad pharmaceutical policy issues and monitor the activities of the Secretariats.

• Smaller, more focused expert working groups or sub-committees should be identified (in a transparent way) and charged with discussing specific issues (e.g pricing) and making recommendations to the Council.

Important observations

• All seven pilot countries established a MeTA Council where the three stakeholder groups were represented and engaged.

• The ‘shared space’ built new levels of trust and created a unique, dynamic and productive set of relationships. Creating this ‘shared space’ requires time and patience.

• Shared working on a particular aspect or task makes a huge difference – the process (of working together) matters as much as the outcome.

• The participants were not paid to take part – the investment of their time and energy shows a significant degree of commitment to and engagement in the programme.
Leadership and co-ordination

Given the different political structures (both formal and informal) across the pilot countries, there was no one stakeholder group that emerged as the natural leader across the board. In some of the countries it made sense that MeTA be closely linked to and chaired by government, in others it was clear that a more independent body, led by an independent chair, would be more effective. In other countries the chair was rotated regularly between the stakeholder groups, or a co-chair from each sector was selected.

No one way worked best but the different leadership models have had different impacts. The Councils that were more closely aligned with or led by government have had an increased capacity to influence policy. Those which were led by the CSOs have been more often focused on awareness-raising and advocacy. Where the chair was rotated it was felt that momentum was easily maintained and there has been a good deal of collaboration.

What was obvious from every country was that the success of the leadership depended not so much on which stakeholders provided the chair but that they embodied a particular set of skills and qualities (see below) and were effectively linked into the decision-making bodies.

The national MeTA Secretariat

The support provided to the MeTA Council, in terms of the national secretariat, has also emerged as a key factor in its success. The secretariat became the ‘engine’ of the programme in each country. The fact that the Council members came together on a voluntary basis meant that their engagement and participation relied heavily on the day to day work of the country coordinators. These coordinators have been essential in convening the groups, presenting them with technical reports and information (in a way they could all understand) and taking forward the work plans.

Lessons from the pilot:

• The chair should have:
  ► Influence – access to and the respect of decision-makers in each sector – but particularly government
  ► Goodwill – the respect for and from each of the stakeholder groups
  ► Balance – an understanding of the motivation and context of each stakeholder
  ► Lack of corruption – a solid reputation

• The national secretariat should aim to have a minimum of two individuals – an administrator with financial and administrative responsibilities and a coordinator with technical expertise who understands the data and can present an overview of all the baseline work whilst tracking outcomes and impacts of the activities.
“Three groups – government, civil society and industry – started working together in a way they had never done before. Now, these sectors work together so that the power and responsibility belongs to all of them. Together, they own the outcomes. This is the strength of the Medicines Transparency Alliance. It was difficult to believe that this might happen – that we would work together. But it really did happen – thanks to MeTA and the pilot.”

Dr Elías Melitón Arce Rodríguez,
Vice Minister, Ministry of Health, Peru
The second essential step in the MeTA process is to build as full a picture as possible of the existing situation with regard to the price, quality, availability and promotion of medicines. This information enables the Council to present evidence of where the problems lie, propose strategies to tackle them and track progress, using country-specific indicators. The unequivocal nature of this robust and unbiased data (which has been collected and analysed by all three stakeholder groups) means that discussion is more immediately focused on the problems and not the validity of the information. It also allows for an evaluation of how MeTA has supported improved access to medicines in the participating countries beyond the pilot phase.

In the majority of the pilot countries, very little of this data already existed or was publicly available. Over the course of the MeTA pilot, a number of tools were developed and used to build a composite picture of the pharmaceutical supply chain and markets and to decide how best to use this information. These tools – some purpose built for the programme, others adapted from existing programmes – have now been collated as an innovative ‘toolbox’. They provide methodologies, guidance and strategies for identifying where the main information gaps lie, collecting this data and, ultimately, disclosing it.

Each country – supported by the International MeTA Secretariat – undertook a review of their pharmaceutical sector, beginning with a baseline situation analysis.
MeTA baseline assessments

Three key components to this assessment were applied slightly differently in each country depending on the national situation and available resources. These components are:

- **Component One:**
  An inventory of existing pharmaceutical sector data that is then made publicly available.

- **Component Two:**
  An indication of the degree of community access to essential medicines, through healthcare facility and household surveys.

- **Component Three:**
  An indication of the quality of the multi-stakeholder process, which includes a 360-degree assessment of the existing levels of engagement.

Pilot countries have now completed baseline data collection and analysis, and this work has taken a great deal of the pilot phase. This can be put down to a number of factors which need to be considered for future projects. Feedback from the countries indicates that, at the outset, despite their intention to conduct medicines situation analyses as part of their work plans, they were not fully aware of the need for the different components of the baseline and the time and skills that would be required. In addition, some of the baseline assessment tools were not available at the beginning of the programme which led to an unhelpful overlap with the implementation of the country work plans – i.e. priorities and objectives were being set before they could be fully supported by updated and validated facts and figures.

**“MeTA is an innovative initiative that is country focused and promotes improved access to medicines through more transparency, accountability and the efficiency of the country pharmaceutical sector. WHO is actively contributing to strengthen capacity in countries to ensure that quality information on medicines is generated and disclosed. Its privileged relationship with its member states and its strong country presence have allowed WHO to play a key role with decision makers – advocating the value of MeTA and promoting policy dialogue with stakeholders such as the private sector and civil society.”**

**Dr Gilles Forte, World Health Organization**

**Lessons from the pilot:**

- **Sequencing** – undertake the baseline medicine situation surveys as early as possible and allow sufficient time and resource for results to be available before the development of the national work plan.

- **Technical capacity** – ensure that individuals with the right technical expertise are in place to conduct the surveys and analyse and translate the data into meaningful information to help shape the work plan.

- **Flexibility** – allow for modification of work plans when and if new and significant data emerges that requires a shift of priorities or redesign of activities.
**Important observation:**

Each of the pilot countries has new, good quality data that has been validated by each of the three stakeholder groups. This means that future decisions and policy recommendations are based on sound data and that, crucially, the debate has moved from a discussion about “which facts and figures are ‘true’?” to “what are we going to do about it?”

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**Sharing information**

Transparency is a precondition for involvement in the MeTA programme. Through the process of data disclosure, weaknesses in the medicines supply chain can be identified and, through the multi-stakeholder discussion and analysis process, solutions can be proposed and jointly agreed.

Nonetheless, the issue of ‘disclosure’ of data can be a delicate one. The MeTA pilot has shown that there are equity issues to consider and sensitivities surrounding the release of certain types of information – particularly into the public domain. For example, businesses will not want to disclose information that might put them at a competitive disadvantage and governments will be reluctant to expose information – such as unethical practices or bureaucratic inefficiencies – that might cause political ‘damage’. Indeed, disclosure of certain confidential or potentially ‘damaging’ information – or merely the threat of that disclosure – might jeopardise the entire process. This risk needs to be fully understood and built into the process from the outset.

MeTA has also shown that, despite these issues, disclosure is possible – every pilot country has completed the Component One baseline surveys and disclosed this data.

It has become clear that disclosure becomes less fraught and less risky if, at the outset, the multi-stakeholder groups discuss whether and how data disclosure might benefit or disadvantage different suppliers and consumers of medicines and agree a manageable, appropriate and fair system for the collection and disclosure of data. Building this sense of trust and understanding between the stakeholders is crucial. If there is mutual recognition that this information will not be abused or misrepresented and that its disclosure will inform rational, sensitive and, if necessary, confidential debate, then the relevant parties are more inclined to share.

The MeTA model proposes that each stakeholder discloses certain types of information related to the price, quality, availability and promotion of medicines. These include, for example:
• Public sector – government: VAT, taxes, health and medicines budgets, selection, quantification and trade statistics (import/export data)

• Public sector – procurement agency: purchase and selling prices

• Public sector – Drug Regulatory Authority: quality and registration data, Good Manufacturing Practice and Good Distribution Practice inspection results, Quality Control laboratory results

• Public sector – health insurance: list of the medicines that are covered and how much the health insurance contributes to the cost of these medicines

• Private sector: manufacturing prices, wholesale and retail margins, availability, promotion codes of conduct, market information

• Civil society and academics: availability of medicines to all income levels in society and how affordable they are; how and if patients are using medicines appropriately (rational use) – through household surveys.

The extent to which this information is readily available and the level at which the relevant stakeholder will accept disclosure will vary from country to country and from business to business which is why upfront agreement is so important.

The MeTA pilot has shown that there are ways in which the disclosure of this information – particularly that which is commercially sensitive – might be successfully managed and that data can still be useful for policy-making purposes without necessarily making all commercial details available. For example, commercially sensitive data could be submitted to a third party, for aggregation, analysis and representation. Organisations that could fulfill this role include: accountants, auditors, academic institutions and independent drug information centres.

The level of private sector engagement has differed from country to country and some national forums are still seeking greater participation. However, there is a growing recognition within the industry of the widespread advantages of being involved in the MeTA process and the engagement to date has allowed information to reach the public domain that would not have previously been available. Businesses engaged in the MeTA pilot have agreed to share prices, publicise the codes of ethical promotion and engage in the debates on how these codes can be improved and more widely applied and how they can work proactively with Drug Regulatory Authorities (DRAs) to improve quality.

Lessons from the pilot:
• Do a risk assessment and a risk management plan at the outset – “If we succeed....what are the risks? How do we manage them? What do we do if/when stakeholders or other players react negatively to public disclosure of certain information?”

• Layered disclosure – sensitive information might be disclosed incrementally, aggregated and/or held by a third party.
Accountability

The clear advantage of sharing this new information between the stakeholders and releasing it into the public domain is that there is irrefutable confirmation of where responsibility for limiting access to medicines lies and who therefore is responsible for change. Individuals and organisations can then be held accountable for implementing this change.

There is a well-known expression, “Knowledge is power”. A consumer who knows that a medicine can be bought more cheaply from another supplier or in another part of their region can demand a fairer deal. An industry executive who knows that government bureaucracy is holding up the supply of their medicines can call for change. A CSO who knows that a retailer has put an excessive mark-up on a medicine or is selling counterfeit medicines can alert the relevant authorities.

Through the process of agreeing together the priorities and objectives of the work plan, a sense of mutual accountability is created and the stakeholders commit to each playing their part in delivering on these goals. And by becoming part of the ‘MeTA community’ they commit to the global MeTA aim of increasing access to medicines.
Translating evidence into policy and practice

The final stage of the MeTA process is the translation of this evidence into tangible outcomes. Each MeTA Council has developed a work plan that outlines the factors limiting access to essential medicines, prioritises the actions and policies needed to tackle these factors and agrees the outputs and outcomes of the programme.

The pilot countries have now reached the ‘implementation phase’. The creation of the multi-stakeholder groups and the collection and validation of data has allowed the outputs of the work plan to be understood or agreed. More importantly, the time taken to create relationships of trust and build accountability for the outputs has meant that there is a greater likelihood that the outcomes will be achieved in an accelerated timescale.

At the start of the MeTA project, whilst the overall goal of increasing access to essential medicines was unambiguous, the specific ways in which this might be achieved were not so clear. MeTA deals with complex political and technical issues and over the course of the pilot it has become clear that, for the project to be sustainable in each country, the specific challenges and outputs needed to be identified and agreed by the national Councils on the basis of sound evidence and solid relationships.

As a result, success has been measured in a number of ways. There are both quantifiable outputs (for example, the publication of particular sets of data) and less tangible (but equally important) qualitative outputs (for example, the creation of an effective multi-stakeholder Council).

The experience of the pilot has shown that there are some objectives that should be applicable to all:

- Creating an effective multi-stakeholder alliance
- Completing baseline surveys which give a full picture of the pharmaceutical market and supply chains
- Disclosing this information and using it to form a plan of action for change.

Beyond this phase and on the basis of the data collected, more specific outputs can then be identified which deal with:

- The price of medicines – identifying specific reductions for certain medicines
- The quality of medicines – eradicating sub-standard and counterfeit medicines
- The availability of medicines – ensuring adequate stock levels where they are needed
- The promotion of medicines – enacting and enforcing legislation that ensures medicines are ethically and honestly promoted by producers, suppliers, distributors and retailers.

Lessons from the pilot:

- Meaningful work plans need to be based on a clear understanding of national contexts and the challenges of access to medicines facing key sectors of the population
- Work plans must contain clear agreed qualitative and quantitative goals
- There should be effective and regular monitoring and evaluation processes in place to measure outputs and eventual impacts over time (years rather than months).
Achievements

The specific goals agreed by the individual MeTA Councils have been wide-ranging and, in every pilot country, the dedication and commitment of stakeholders have already achieved some important results.
Medicine quality assurance

In order to strengthen quality assurance of essential medicines, MeTA Ghana and the World Bank have funded and worked with the Ghana Food and Drugs Board to test the quality of antibiotics and other medicines using minilabs at sentinel sites around the country.

This work has contributed to swift intervention by the regulator through the identification and recall of some substandard antibiotics and withdrawal of unregistered medicines from the market. This was extensively covered in the national press and has raised public awareness about medicine quality. It highlights that ensuring the quality of medicines is a strong common goal for all MeTA stakeholders.

Raising awareness

To build an effective advocacy network and a more informed ‘consumer base’, the Ghana MeTA Civil Society Group was formed. This group has focused on raising public awareness and advocacy capacity – taking the country’s significant regional, cultural and linguistic diversity into account.

Over the past year and a half, the civil society network has grown steadily – from a core team of just four CSO representatives to a diverse network of more than 100, covering all ten regions of the country. Communication materials have been developed and translated into seven local languages. They are being used by community-based organisations and cover important health issues from a patient and community perspective, with an emphasis on consumer protection.

Health Insurance

MeTA is working alongside the National Health Insurance Authority to extract information from its electronic database according to agreed indicators. The electronic data are being validated with additional primary data on availability, pricing and rational use collected from health facilities across three regions. This joint data collection and analysis will help to inform evidence-based policies and help regulators to enforce existing laws and guidelines of the Ministry of Health.

“...The Medicines Transparency Alliance brought stakeholders together – and has catapulted us forward. We are revising procurement laws and our medicines policy to reflect the need for transparency and multi-stakeholder decision-making.”

Samuel Boateng, Office of Chief Director, Ministry of Health, Ghana
Transparency in the selection of essential medicines

The classification of medicines (restricted, unrestricted, authorised and unauthorised) in the Rational Drugs List has been reviewed by MeTA expert committees. Transparent, detailed evidence-based regulations and processes have been recommended for the implementation of the classification and the selection of medicines. The Rational Drug List will be revised accordingly, as part of the national work plan, helping to improve the purchase, supply and delivery of essential medicines in the public health system.

Rational use and Standard Treatment Guidelines (STGs)

As part of a strategy to improve rational use and tackle unethical promotion of medicines, gap and situation analyses for the availability and use of STGs in different health facilities in Jordan have been commissioned by MeTA Jordan. Although some public institutions have STGs, no unified national STGs for the public sector exist.

Standard, evidence-based guidelines for the pilot treatment of essential hypertension have been developed by MeTA Jordan in collaboration with UK National Institute for Clinical Excellence, funded by the World Bank and the UK Department of Health’s Global Strategy programme. As part of the wider strategy to improve the rational use of medicines by prescribers and patients and the availability of medicines, this STG will be piloted within primary healthcare centres of the Ministry of Health.

Multi-stakeholder policy-making

MeTA Jordan has initiated a review of the National Drug Policy (NDP). The Consumer Protection Society has an expert that sits on the review committee, alongside government and the private sector. For the first time CSOs have direct input into policy-making processes related to medicines.

Updated information on the pricing of medicines from the Level II Health Facility and Household Surveys have just been disseminated, indicating that compared to an international reference price, the cost of medicines in the private sector is much higher than in the public sector (up to 20 times for patented medicines and 11 times for generics). The disclosure of this information, teamed with a more powerful CSO voice in Jordan is anticipated to lead to some decisive changes in the pricing structure of these medicines.
Kyrgyzstan

**Medicine quality assurance**

As part of the awareness campaign on counterfeit medicines, a Drug Quality Survey was initiated by MeTA Kyrgyzstan. Training on the use of mini-labs was conducted and samples have been collected for quality testing. In total, more than 400 samples have been collected in randomly selected pharmaceutical outlets in the capital Bishkek and in three other major towns. Eighteen per cent of samples were found to be unregistered, and were thus being sold illegally. The tests have been carried out by the Drug Regulatory Agency (DRA) Quality Control (QC) laboratory and by trained staff from the Pharmaceutical Department of the Kyrgyz State Medical Institute. Initial results obtained from the Pharmaceutical Department indicate that there are several ‘questionable’ samples. These will undergo further analysis by an independent laboratory. The results of the quality testing will inform the awareness campaign.

**Establishing an effective multi-stakeholder alliance**

Soon after the official launch of the national Medicines Transparency Alliance project in April 2009, it became apparent that the commitment and engagement of the civil society organisations would be more effective if they formed a coalition. The MeTA CSO Coalition was formalised in September 2009 and its launch, which outlined the MeTA aims and plans listed above, drew significant attention from local and national media – including four major news channels. As a result, the MeTA CSO Coalition gained substantial support and impetus and is now active in organising capacity building training. It has also agreed with regional authorities to participate in the procurement of the medicines in one region of the country. Recently, the CSO Coalition has initiated a small working group which is working with the Ministry of Finance on a new draft of its procurement law and is now permanently included in the Ministry of Health Tender Committee for all medicines.

Since the change of government in Kyrgyzstan, following the political uprising on 7 April 2010, MeTA Kyrgyzstan has begun to involve private sector representatives in its discussions. The Association of Local Pharmaceutical Manufacturers and several private companies are now working with a MeTA expert group to look at existing pharmaceutical legislation and identify ways in which it might be adapted to create more transparency and accountability in the medicines supply chain. It is anticipated that this work will help to get more data in the public domain – benefitting both business and, ultimately, the consumer.

The private sector is working closely with National Drug Regulatory Authority and the Ministry of Economic Development regarding the law on licensing and permissions and is aiming to work with these bodies on legislation about the deregulation of the pharmaceutical sector.

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**Kyrgyzstan**

Population: 5.6 million

Life expectancy at birth: 68 years


HDI rank: 109

Human Development Report 2010, UNDP
Data disclosure
MeTA Peru focused its efforts on developing a Price Observatory to give the public access to accurate information about medicine prices. Its specific contribution was in writing the draft legislation that would both acknowledge the Price Observatory nationally and require all medicine producers and sellers – both public and private – to publish their prices.

The Minister of Health signed the legislation for the Price Observatory in January 2010. It is now being prepared and soon a database of medicine prices will be accessible, which will allow the public to make informed choices about where to get their medicines.

With this new tool MeTA Peru has contributed to active participation in price checking on behalf of average citizens as well as by civil society groups who are monitoring prices and availability of medicines in the country. Finally, the expectation is that the Observatory will help to bring down prices, improving access to essential medicines among the population.
Legislation
MeTA Philippines’ Council members participated in the debates leading up to the ratification of the ‘Universally Accessible Cheaper and Quality Medicines Act’ of 2008 (Republic Act 9052). There was intense and often difficult debate between the perceived ‘opponents’. Bringing the Council members together at this time (as representatives of opposing stakeholder groups) was an achievement in itself. The Act was signed into law by the President of Philippines on 6 June 2008. MeTA was invited to provide input into the implementation plan for the Cheaper Medicines Act.

Multi-stakeholder engagement
MeTA Philippines has brought in private sector participation to its monthly Council and annual forums, and has supported the formation of a civil society coalition – the Coalition on Health Advocacy and Transparency (CHAT). The forums have provided an opportunity for pharmaceutical sector monitoring and assessments to be presented, which has led to an informed and evidence-based debate among stakeholders on what policy recommendations are needed. The Department of Health (DoH) has now adopted, for the first time, a multi-stakeholder advisory process for monitoring, consulting and obtaining advice on implementation of medicine price regulation.

A number of multinational companies have agreed to government-negotiated voluntary price reductions for some commonly prescribed medicines for chronic conditions.

The 2010 version of Philippines national medicines policy is expected to be released soon with input from MeTA Philippines.

In January 2010, Philippines issued the first Good Governance for Medicines Award. This is a World Health Organization/Good Governance for Medicines initiative which has been implemented by the DoH with the collaboration of MeTA Philippines.

Equity and a Universal Healthcare Programme
Universal health coverage for all Filipinos by 2013 is a commitment made by the new President. MeTA has adopted this as a priority area, and organised the summit on universal health care with the aim of submitting a multi-stakeholder policy paper to the government. CHAT is the lead in a CSO health policy advocacy group in pushing universal health care legislation and increase in health budgets.
Uganda

Data disclosure
MeTA Uganda supported the National Drug Authority in making the database of registered medicines available on its website. This database of registered medicines is now searchable online. It has been advertised in the newspapers along with the SMS information service whereby clients can inquire about the registration status of a drug, pharmacy, drug shop or manufacturer. This has generated much interest among members of the general public who are providing NDA with feedback on its operations especially with regard to medicines registration and quality. It is intended that this will also lead to improved intra-government efficiency as NDA verification information will be available to the Ministry of Health. In addition, the private sector has obtained and used the information generated and produced by the process. For example, the price monitoring and availability reports have informed of the need to generate evidence on margins and mark-ups which has led to a further study on price components and the project with NDA to ascertain the volume and value of imports. The private sector now has an avenue for access to information that was not easily obtainable such as the medicines price monitor and the three year rolling procurement plan of the Ministry of Health. This information on the pharmaceutical market is and will continue to be utilised in variable ways to increase access to medicines.

Multi-stakeholder policy making
The private sector and CSOs have been invited to join discussions with the Ministry of Health on the National Pharmaceutical Sector Strategic Plan.

Consumer strength
The “Stop the Stock Outs!” campaign – led by the CSOs – was extremely successful in raising public awareness and driving the issue up the political agenda. As a result a Drug Monitoring Unit has been established in the President’s Office.
Outreach programmes
In order to raise the public’s awareness of their rights as patients and their entitlement to good quality, affordable medicine, MeTA Zambia initiated outreach programmes in two districts of the rural North Western province in August 2009. In early March 2010, three ‘road shows’ were also taken into local rural communities.

MeTA Zambia has also embarked on a national media campaign. Half hour programmes on community radio have been broadcast and a one hour live phone-in radio programme was organised, where local community members were able to discuss their concerns or ask questions about the MeTA initiative.

For the urban populace, one live national TV programme was broadcast early March 2010 and weekly live radio programmes are running regularly. Community feedback has been extremely positive – the issues were widely understood and community leaders are reacting to the messages.

Parliamentary debate
A motion in parliament in March 2010 enabled both ruling and opposition Parliamentarians to debate all matters pertaining to the availability, accessibility, quality and pricing of medicines on the floor of Parliament and, consequently, raised the MeTA Zambia profile with the policy-makers and the general public.

The Ministry of Health has approved the piloting of a new project aimed at upgrading the provision of essential medicines through the various outlets at rural and peri-urban level.

Consumer strength
MeTA Zambia has now become part of the National Medicines Review process.
Conclusions

The Medicines Transparency Alliance set out to test the hypothesis that introducing transparency into the medicines supply chain would increase accountability and that this would, in turn, bring about a change in policy and activity, so that the poorest members of society would have better access to essential medicines. Importantly, it also set out to show that this could best be achieved by involving all of the relevant stakeholders by creating what we now confidently call MeTA multi-stakeholder groups.

Over just two and a half years, the seven pilot countries have tested this hypothesis to the full and, as we have seen, this innovative and bold project has already resulted in some exciting and positive outcomes.

New and unique relationships have been built. The strength of MeTA is that it provides a safe platform for stakeholders with often divergent interests and perspectives to discuss issues and agree on action, even where some divergence of opinions remains. Every pilot country has established a multi-stakeholder working group. Former ‘opponents’ or ‘adversaries’ have begun to understand and trust one another as they work on priorities and projects together. More importantly, responsibility is now being shared and concrete actions are being taken by members of civil society, private and public sectors in each of the pilot countries to improve the information and accountability for access to medicines. Countries are actively sharing their experiences and learning from each other. There is a far better understanding of how to get the very best out of the individuals and multi-stakeholder groups involved.

New data is available. Every pilot country has collated, validated, analysed and shared fundamental data that has formed the basis of work plans and policy recommendations. Much of this data did not exist or was not easily available and in some cases its collection and disclosure seemed improbable, if not impossible.

There are also some important lessons that have been learned over the course of the pilot.

Creating an alliance

• It is important to have a deep understanding of the political and social context into which MeTA is going to be introduced.

• Building trust and confidence between stakeholders is crucial but it takes time, skill and patience.

• A level playing field is necessary for the stakeholders to work constructively together – some groups may need external help to build the capacity and skills needed to participate effectively.

Generating Evidence

• Baseline and disclosure surveys conducted within a multi-stakeholder process generate a wealth of new information that can provide evidence for sound policy development, action and measurement of progress and results.
Personnel with technical and pharmaceutical expertise are needed to collect, analyse and present the data.

Data disclosure needs to be carried out sensitively to ensure the long-term collaboration and co-operation of all stakeholders.

**Translating evidence into policy and practice**

- Activities need to be agreed and led by the country, based on its own needs
- A ‘layered’ approach to accountability can ensure that relevant individuals and organisations take responsibility for change. The well-informed consumer can demand the right medicines at the right price; the strong CSO can provide a powerful voice that the private sector and government cannot ignore; the informed industry executive can demand that the government tackles bureaucratic inefficiencies; and the global MeTA community can hold governments and corporations to account on the international stage.

**The Global Alliance**

- An international layer of support is important – to lend influence and guidance, help with capacity and resources and ensure the country teams do not feel they are working in isolation.

The MeTA pilot has been ambitious. New theories, new relationships and new tools have been put to the test in seven very different countries. The pilot countries are now beginning to implement changes to policy and practices. It is evident from their energy, leadership and commitment that the new relationships are strong and that momentum has been created. The new tools have been tested and refined so that they can be used in other countries to develop similar programmes. The issue of access to medicines has moved up the agenda and more and better quality information on the medicines supply chain is now available in the public domain.

The MeTA pilot has been a global experience and its impact is potentially very profound; effecting fundamental change in the structure of pharmaceutical markets and supply chains to increase access to medicines. It has proved to be a viable, successful and sustainable project and has created a strong legacy for other countries to explore and develop.
For further information, please contact:

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