

# **MeTA country guidance note:**

## **Moving towards medicines data transparency, joint analysis and evidence-based policies to improve access to medicines**

### **Introduction**

The Medicines Transparency Alliance (MeTA) is a global health initiative focused on improving access to quality-assured medicines in developing countries by increasing transparency and accountability in the pharmaceutical sector. The initiative was launched in April 2008, and its pilot phase ran until late 2010.

The purpose of MeTA's pilot phase was to encourage a new multi-stakeholder approach designed to increase transparency around the selection, regulation, procurement, sale, promotion and distribution of medicines. Through this approach, the initiative aims to strengthen governance, improve efficiency, and encourage innovative and responsible business practices.

During its pilot phase, seven countries implemented MeTA: Ghana, Jordan, Kyrgyzstan, Peru, the Philippines, Uganda and Zambia. These countries developed 2-year workplans, formed multi-stakeholder groups (generally called MeTA Councils) and set up national Secretariats. By the end of the pilot phase, they had collected and shared data on the selection, procurement, quality, availability, pricing, promotion and use of medicines – thereby completing the first steps in the MeTA cycle.

### **Purpose of this guidance note**

The purpose of this note is to provide advice and guidance to existing and prospective MeTA pilot countries – and specifically their national Secretariats and multi-stakeholder groups or Councils – as they take steps towards establishing the practice of routine disclosure of key medicines data.

This note also offers some tools and examples to aid the disclosure process, shares case studies and lessons from different countries, and identifies potential sources of technical assistance (TA). This will help to ensure some degree of standardization of routine reporting across the MeTA countries, which will in turn aid comparison, peer support, and monitoring and evaluation.

### **MeTA Goal and Principles**

The initial aims and objectives of MeTA, as well as its broad approach, are set out in the original proposal document [Medicines Transparency Alliance: Implementing Our Pilot Phase](#) and in the associated [summary note](#).

All stakeholders engaged in MeTA have signed up – at least implicitly – to the core principles upon which the initiative is founded. These state that:

- Governments are responsible for providing access to health care, including access to essential medicines.
- Stronger and more transparent systems and improved supply chain management will increase access.
- Increasing equitable access to medicines improves health and enables other human development objectives to be achieved.
- Improved information about medicines can inform public debate, and provide a basis for better policy.
- A multi-stakeholder approach that involves all sectors (private, public and civil society) will lead to greater accountability.

The principles of MeTA reflect its core hypothesis: that the disclosure of key medicines data (i.e. putting data into the public domain) will make the workings of the pharmaceutical sector, including the supply chain, more transparent, and that this will enhance efficiency, incentivise responsible business practice, and increase the accountability of key stakeholders – to each other and to the public.

The MeTA model – as articulated in the pilot phase proposal cited above – proposes that four types of data be put into the public domain in MeTA countries, along with additional contextual information.

Data on:

1. Quality and registration status of medicines
2. The availability of medicines
3. Medicine pricing
4. Policies concerning the ethical promotion of medicines

Contextual information on at least:

1. Supply chain operations
2. Medicine affordability
3. Equitable access
4. Rational use of medicines

For each of the broad areas outlined above, disclosure is expected to cover:

- Policies – what relevant laws, regulations and policies are in place?
- Practices – for example, what is the procedure for the registration of drugs?
- Outcomes – for example, what are the pricing outcomes achieved through public procurement?

In MeTA pilot countries, the multi-stakeholder approach has been embodied in the national multi-stakeholder group (or Council, as many pilot countries called this group), which brings together representatives from the public, private and civil society sectors to share, discuss and analyse medicines data and then use this evidence to inform policy and practice across the three sectors. MeTA countries also organise larger multi-stakeholder Forums to share information across a broader

group of interested constituencies, including the media, and to stimulate public debate on medicines issues.

During the MeTA pilot phase, valuable lessons were learnt about how to use a multi-stakeholder approach to achieve lasting impact on health and development outcomes. For example, all MeTA Councils found that building trust between different stakeholders takes time. Some stakeholders may struggle to position themselves effectively alongside others. In many of the pilot countries, civil society organizations took some time to find their voice and to get themselves heard.

Such challenges are to be expected. It is important that they are worked through during the early phase of MeTA and a productive Council dynamic established, if data are to be disclosed and discussed.

The MeTA pilot was evaluated in early 2010. The [evaluation report summary](#) is available online, and country evaluation reports offer valuable lessons. The evaluation concluded that the core MeTA hypothesis had not yet been proven or rejected, not least as data disclosure had not yet progressed to the level at which transparency and accountability might be strengthened. MeTA pilot countries engaged in greater data disclosure and discussion during the last six months of the pilot phase, after the evaluation had been conducted.

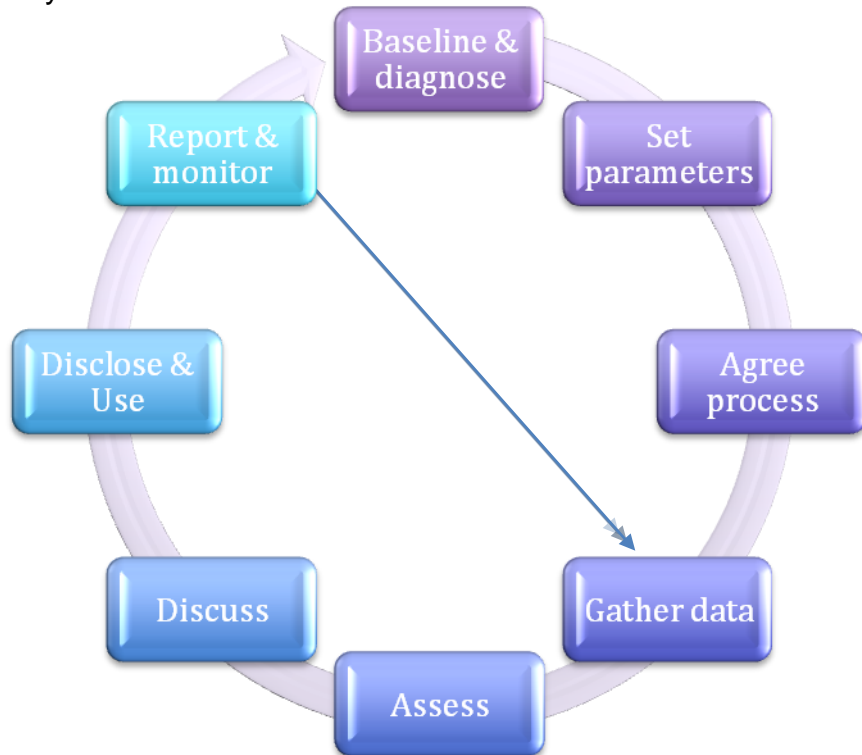
### **Moving towards medicines data transparency: a phased approach**

This section of the guidance note outlines the different steps in the MeTA cycle, which multi-stakeholder groups can follow once they are established and have agreed how they will operate. The key steps in the MeTA cycle – which are explained in more detail below – are:

1. Defining a baseline and diagnosing challenges or gaps
2. Setting parameters
3. Agreeing the process
4. Gathering data
5. Assessing data
6. Discussing data between stakeholders
7. Using data and making them public
8. Reporting and monitoring

MeTA countries will aim to work through these steps – sequentially, but necessarily with some overlap – and to maintain this process over time. With each cycle, it is hoped and anticipated that greater amounts of information will be disclosed and that multi-stakeholder discussion of data will become increasingly open, frank and productive.

The MeTA Cycle:



It will take some multi-stakeholder groups more time than others to work through this phased approach. Change does not happen overnight. What matters is the direction of travel.

### 1) Defining a baseline and diagnosing challenges

Focus: mapping the current level of data transparency and use.

It is important that all countries embarking on the MeTA process know their starting point. How much information is already put into the public domain, by which organizations, and on which topics? How is this information disseminated and used? Where are the major gaps in available data? How do different stakeholders relate to one another, and are they having an impact in improving access to medicines currently?

These and other questions form part of the MeTA baseline assessment.

In the seven MeTA pilot countries, this baseline assessment was conducted after MeTA Councils had agreed an initial workplan, as standardized tools had to be developed before countries could proceed with their assessments. However, the results of baseline assessments helped to refine or reorient those workplans. It is envisaged that, from now on, countries joining MeTA will undertake the baseline assessment at a very early stage, to inform workplan development and to foster familiarity with the MeTA principles and model.

The baseline assessment also helps MeTA multi-stakeholder groups or Councils to develop national indicators, which can be used to track progress in improving transparency and accountability through information disclosure and stakeholder engagement. However, just as importantly, the baseline data provide the foundation for longer-term evaluation of MeTA's global outcomes and impact.

There are [three key components](#) to the MeTA baseline assessment:

- Component One: An inventory of existing pharmaceutical sector data, in two parts (a pharmaceutical sector scan focused on basic health and medicines data, and a survey focused on data disclosure and transparency), both of which are then made publicly available;
- Component Two: An indication of the degree of community access to essential medicines, through healthcare facility and household surveys, which are then made publicly available;
- Component Three: An indication of the quality of the multi-stakeholder process, which includes a 360-degree assessment of the existing levels of engagement. This is a largely internal assessment, but findings may be made publicly available in full or in part, for example in summary on the national MeTA website and/or in an annual report.

The assessment undertaken in each country will vary depending on the local situation. Not all the components will be used in all countries. Each country's decision about which components to cover is taken through discussion within the national MeTA Council and with international and local development partners and agencies (who may already be financing household surveys, for example). In general, as a minimum, countries participating in MeTA would be expected to complete components One and Two in order to generate a baseline, though this will be dependent on sufficient resourcing.

In addition to the core tools developed by MeTA, countries may find a number of other survey and assessment instruments helpful in developing an understanding of the current national context. These include the tools developed by Health Action International (HAI) and the World Health Organization (WHO), listed below. Data from Demographic and Health Surveys, National Health Accounts, and other surveys may also be valuable and will provide robust sources of primary information for the MeTA baseline assessments. Much of the data needed to complete MeTA baseline assessments will already have been generated, but the baseline assessments enable countries to pull such data together in one place and identify gaps.

Once the baseline data have been gathered by MeTA Secretariats (or by volunteers or consultants), these should be presented to national Councils for validation, discussion and collective analysis. The availability or otherwise of key data must be commonly understood, before decisions can be taken about how to pursue the longer-term collection, assessment, discussion, disclosure and use of key medicines data.

In this sense, the MeTA baseline assessment process is a microcosm of the overall MeTA cycle outlined in this guidance note, with data gathered, validated, discussed and analyzed, before being put into the public domain.

### Tools:

- Core tools: MeTA [baseline assessment toolkit](#), which covers components One, Two and Three as outlined above.
- Additional tools: WHO assessment instrument '[Measuring transparency in the public pharmaceutical sector](#)'; WHO and Health Action International manual '[Measuring medicine prices, availability, affordability and price components](#)'; the MIT-Zaragoza [supply chain mapping tool](#); and the WHO '[Data Collection Tool for the review of drug regulatory systems](#)'.

### **Example: Jordan baseline assessment**

MeTA Jordan was one of the first countries to undertake the MeTA baseline assessment. The MeTA Jordan Council embarked on the assessment as a collaborative exercise, meeting three times in quick succession to complete the Component One [data disclosure survey](#) and to validate the data provided by responsible institutions.

The MeTA Secretariat co-ordinator developed an additional template to capture and track the findings of the survey tool. This enabled her to more easily identify specific gaps in the availability or use of current data.

MeTA Jordan is reflecting on the [learning from the baseline assessment process](#), and is now considering ways in which progress might be tracked in different areas of data disclosure using a 'ladder' system. The Disclosure Process Ladder they have developed could help MeTA multi-stakeholder groups to map the results of repeated data disclosure surveys by categorizing different data as either 'C: not available', 'B: available but not publicly disclosed' or 'A: available and publicly disclosed'. The aim is to shift the status of key data from C to A over time.

### *2) Setting parameters*

Focus: agreeing which medicines will be focused on for routine data disclosure; agreeing how core data will be collated and reported.

Once baseline data have been gathered and examined, national MeTA Councils and Secretariats will be able to make informed decisions about which data might reasonably be put into the public domain on a regular basis. In some cases, data will already exist as they are already collected by one of the MeTA stakeholders. In other cases, new data will need to be generated from stakeholders' information systems or through the use of survey tools.

The key question for MeTA stakeholders to answer is: which data do policy-makers and the public need in order to ensure the rational use of medicines and secure improvements in health outcomes, whilst also improving the efficiency of the pharmaceutical market and its supply chain?

In order to make the process of medicines data collection and reporting more manageable, countries may find it helpful to agree a national tracer medicines list. Data collected and disclosed on the price, quality and availability of these medicines will form a core dataset that serves as a proxy for the performance of the medicines market and supply system as a whole. Stakeholders can opt to disclose more than this core dataset, of course.

Countries may find it helpful to focus their tracer list – and therefore routine data collection – on the medicines of greatest national importance from a public health perspective and those that have a high rate of use and/or high cost to consumers (particularly the poor). This assumes that sufficient data are already available in these areas, of course. This should have been picked up by the baseline assessment.

If the country is moving towards the proactive disclosure of a specific subset of medicines data on a regular basis, it may be helpful to design and agree a national medicines data collection and reporting template. Ideally, this would cover price, availability and quality data for all medicines on the tracer list, and across all sectors.

Other parameters that the national multi-stakeholder group will need to agree include how frequently data will be collected and put into the public domain. This may differ across data types and across sectors. For example, while it may be feasible to monitor medicines prices and availability on a regular basis, it may be less feasible to collect data on medicine quality (e.g. from regulatory agency batch tests or sentinel surveys, or from studies undertaken by an external agency) and put this into the public domain more than once a year.

#### Tools:

- The WHO/HAI medicines pricing survey [global and regional lists](#)<sup>1</sup> should be referred to by MeTA countries in developing their national tracer medicines list. MeTA recommends that countries select all 14 medicines from the WHO/HAI global list and 16 of the medicines from the relevant WHO/HAI regional list, in addition to local priority medicines, to aid comparison across countries (within and beyond MeTA);
- A country's own Essential Medicines List and national health insurance reimbursement list (if applicable) are also important reference documents;
- WHO/HAI survey tool ([Measuring medicine prices, availability, affordability and price components](#)).
- Suggested proxies for reporting on medicine quality: whether products are registered; whether suppliers are GMP compliant; whether products are WHO pre-qualified or approved by a Stringent Regulatory Authority (SRA). Other useful resources on drug quality monitoring and reporting can be found on the websites of the [Pharmaceutical Inspection Co-operation Scheme](#) (PIC/S), [US Pharmacopeia](#) and the [German Pharma Health Fund](#) (GPHF).
- HAI [materials on medicines promotion](#).

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<sup>1</sup> Go to the heading 'Global and regional core list medicines [English](#), [Spanish](#)' about a third of the way down this web-page.

### **Example: how the MeTA Ghana tracer medicines list was selected**

MeTA Ghana developed a tracer medicines list soon after its national Council agreed an initial two-year workplan – and, in fact, prior to completion of the MeTA baseline disclosure survey. The Secretariat developed a draft list based on data from the National Health Insurance Authority showing the 40 most frequently dispensed (reimbursed) medicines month-by-month, alongside the results of rational use, pricing and availability surveys using the WHO/HAI methodology, and the national Essential Medicines List. Given that the 40 most popular medicines account for around 80% of *all* medicines dispensed under the National Health Insurance Scheme, gathering data about medicines on the tracer list will give a very representative picture of the pharmaceutical market as a whole.

The tracer list is now informing MeTA data collection and analysis. For example, both the World Bank and MeTA Ghana have funded drug quality testing using Minilabs at sentinel sites across all of Ghana's 10 regions. A subset of medicines from the national tracer medicines list was chosen for sampling and testing. The results so far have been striking, which suggests it is worth tracking the quality of the chosen medicines over time, and perhaps repeating the exercise for all medicines on the tracer list in order to get a broader picture of safety and efficacy issues in the supply chain.

### *3) Agreeing process*

Focus: agree a stepwise approach to routine disclosure, as appropriate for each sector (public, private non-profit, private for-profit) and for each point in the supply chain.

As noted above, some types of data may be easier to gather and put into the public domain than others. MeTA countries may wish to take the 'lowest hanging fruit' first – i.e. to focus on gathering, using and disseminating data that is more readily available before moving on to more challenging areas. However, there are equity issues to consider too – multi-stakeholder groups will need to discuss whether and how partial data disclosure might benefit or disadvantage different suppliers and consumers of medicines.

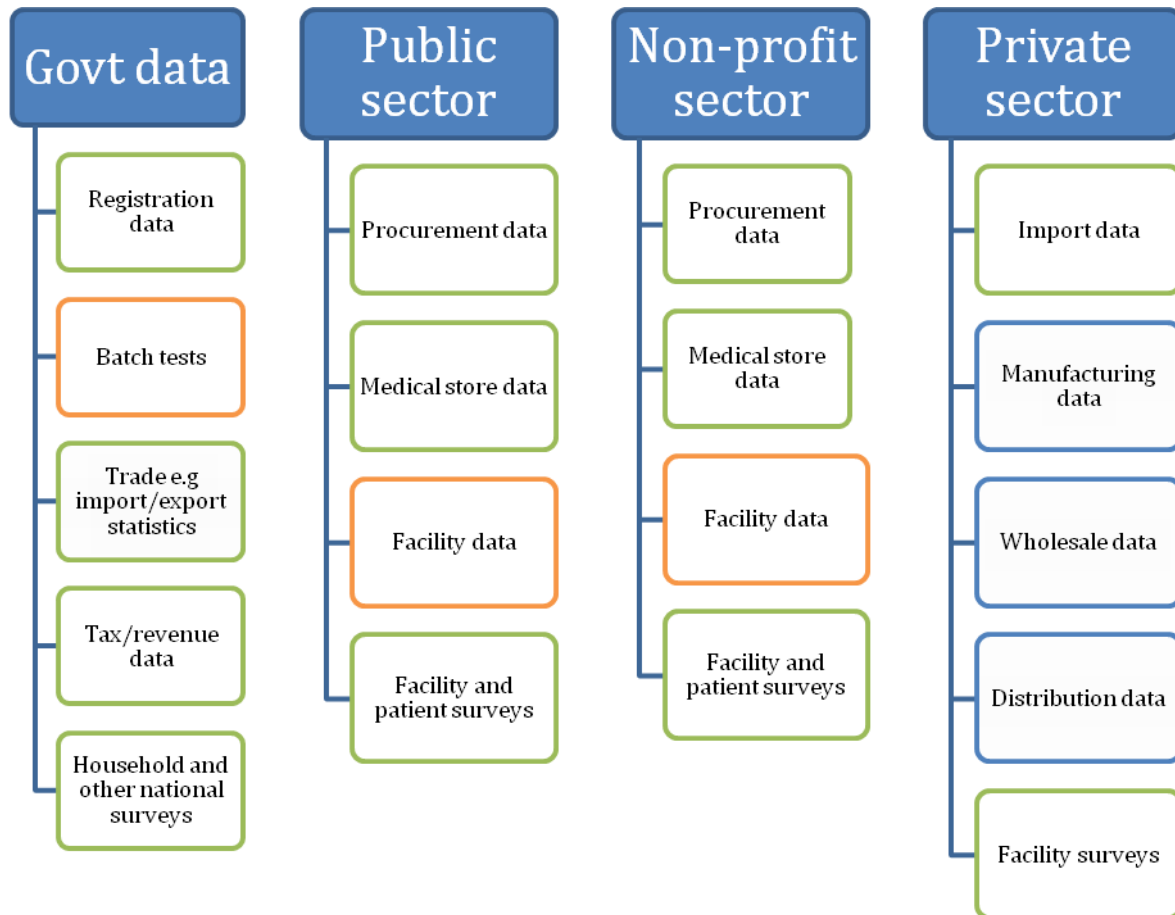
From these multi-stakeholder discussions, agreement must be reached on a manageable, appropriate and fair system for the gathering and disclosure of data. A stepwise approach will probably be most manageable – i.e. starting with one sector, or with data from one or two points in the supply chain, and then building up to a more comprehensive dataset.

The diagram below identifies some of the types of data that might be collected and disclosed. Those that are more likely to be readily put into the public domain are framed in green, with orange for those data that may be routinely collected by a relatively small number of stakeholders but may require a little more effort to prepare for release into the public domain. However, the situation will vary significantly from

country to country, and the baseline assessment process outlined above should pick this up.

Tool:

- MeTA disclosure hierarchy:



4) Data gathering

Focus of this ongoing phase: data are collected by or submitted to the national MeTA Secretariat on a regular basis.

National MeTA Secretariats should seek to gather all data identified by multi-stakeholder groups or Councils for routine disclosure – as well as any supporting information that their national Council wishes to draw on in its discussions.

Data that are already being collected on a regular basis by one or more stakeholder – for example, data collected through a logistics management information system (LMIS) or through routine national surveys such as household, health facility or demographic surveys – can simply be gathered by the national MeTA Secretariat. If new data are required to fill gaps identified through the baseline assessment,

additional studies or surveys may need to be commissioned by the national MeTA Secretariat (on behalf of the multi-stakeholder group) or by one of the MeTA stakeholders. The MeTA Secretariat may also wish to undertake the data disclosure survey (outlined in section 1 above) on a regular basis to track whether or not the sector is becoming more transparent (see Jordan case study in section 1 for some discussion of this).

As countries progress towards more routine data gathering and disclosure, at least for medicines on the national tracer list, the core MeTA dataset will need to be updated regularly. National MeTA Secretariats might consider quarterly or 6-monthly updates to core datasets for disclosure, but every 12 months may be sufficient for some types of data and the needs may be different for quantitative and qualitative data.

The aim of MeTA is to maximise transparency and to facilitate the sharing and disclosure of data that strengthen accountability. However, in some cases, private sector data in particular may be deemed too commercially sensitive to be put into the public domain in company-specific format. Such data could be submitted to a third party, for aggregation and analysis/re-presentation, if deemed absolutely necessary. Local organizations that might serve in this capacity include accountants, auditors, academic institutions and independent drug information centres (where these exist). Any third party would need to be provided with standard operating procedures (SOPs) before being engaged to support MeTA. These SOPs would need to cover procedures for data collection and aggregation, as well as processes for managing conflicts of interest, maintenance of confidentiality etc.

Any data collated by a third-party will then need to be presented in an agreed format – anonymized or aggregated as appropriate – to the national MeTA Secretariat. It is important to note that sensitive data can still be used in detailed form to support policy discussions, even if data are then aggregated or simplified for publication.

Tool:

- The website of [IMS Health](#) holds some examples of aggregate commercial data.

**Example: strengthening data on drug quality in Ghana**

When MeTA Ghana developed its initial workplan in 2008, it quickly homed in on the issue of drug quality. Anecdotally, there seemed to be a growing problem with the presence of counterfeit and/or substandard drugs on the local market, but there was almost no information about the true scale of the challenge.

MeTA Ghana had developed a tracer list of priority medicines (see above) for which recent data on pricing and/or availability were available. The Council selected two medicines from this list – mebendazole and glibenclamide – for an initial round of nationwide sample collection and drug quality testing using the GPHF Minilab, with follow-up tests to be conducted at the Food and Drugs Board lab in Accra. This followed earlier rounds of sample collection and testing conducted for antibiotics and

antimalarials on the list, which were funded by the World Bank (using its MeTA budget line) and the US.

The Food and Drugs Board produced three reports following US Pharmacopeia (USP) protocols. They formed the basis for a series of consumer alerts and product withdrawals (for example, of several [malaria products](#)). The data on antimalarials were also published by USP. All reports were discussed by the MeTA Council and underpinned consumer education and advocacy by the MeTA CSO Group about the quality of medicines on the Ghanaian market.

## 5) *Data assessment*

Focus: analysis of data by the national MeTA Secretariat.

Each country's MeTA Secretariat has an important role to play in the initial assessment of the medicines data it has gathered. Data will be collected by or submitted to the Secretariat in different formats. Key information may need to be extracted from longer reports and reformatted to facilitate comparison and assessment.

Data that will be put into the public domain will also need to be verified - i.e. at least cross-checked, with reference back to the data source if there is anything to be queried. In some more complex cases, it may even be necessary to undertake supplementary data collection to triangulate the original data – the key is to do what is necessary to ensure data are accurate and usable, but not to go overboard and embark on complicated research projects where these are not merited.

The national MeTA Secretariat staff (e.g. technical advisor, Co-ordinator, researcher, where applicable) and/or local MeTA consultant (again, as applicable) should consider how best to present data for multi-stakeholder discussion. This might mean using an agreed reporting template (see above) and/or summarizing data in a powerpoint presentation, or creating a bespoke report in Word (rather than, say, Excel, which can be useful for data collection and analysis, and for generation of charts and graphs, but sometimes results in unwieldy data sheets).

The national MeTA Secretariat staff and/or local MeTA consultant should also attempt to identify key trends and messages from the data, which can then be highlighted to the national Council. This will help to kick-start Council discussions.

### **Example: discussing and using baseline data in the Philippines**

MeTA Philippines undertook its baseline assessment earlier than most MeTA pilot countries, in 2009. The Pharmaceutical Sector Scan – part of Component One of the baseline assessment – was the first attempt at consolidating all pharmaceuticals-related data that were currently available in the Philippines, in a single document. The resulting report contained valuable data of use to policy makers, the industry and the public. However, it was lengthy and required consolidation into a more

digestible format that would facilitate discussion within the MeTA Philippines multi-stakeholder group (Council.)

The MeTA Philippines national Secretariat undertook some analysis of the data in the sector scan and developed some additional products. They drafted an Executive Summary of the scan, pulling all the most significant data together in a series of bulletpoints. They also put together a powerpoint presentation to summarize the scan for the MeTA Council.

The results were presented in a MeTA Roundtable Discussion held in April 2010, which was attended by MeTA Council members, as well as other stakeholder groups (including visiting delegates from MeTA Jordan and MeTA Zambia). During the roundtable, the results of the sector scan were closely reviewed and possible courses of action discussed.

The multi-stakeholder consultation yielded the following resolutions:

- The public sector and the regulatory agency were encouraged to undertake more regular price and quality monitoring;
- Procuring public entities were asked to disclose procurement prices;
- The regulator was asked to disclose to the public the results of post-marketing surveillance activities, particularly reports of adverse drug reactions;
- Private industry was asked to provide more specific information regarding their pricing structures to allow consumers and civil society to better appreciate the concerns of suppliers and brand owners.

## 6) *Multi-stakeholder discussion*

Focus: discussion of core medicines data by the national multi-stakeholder group (Council), focusing on the 'story' the data tell.

Stakeholder discussions supported by medicines data – and, indeed, MeTA baseline surveys, as in the Philippines case study above – should be substantive and systems/policy oriented, with a focus on what the data indicate about the level of transparency and accountability within the medicines supply chain, the level of efficiency in the pharmaceutical market, and the ability of healthcare providers to ensure sustainable access to affordable, quality-assured medicines for patients (particularly the poorest and most vulnerable patient groups).

Key questions that multi-stakeholder groups or Councils might ask include:

- Are there any major gaps in the data being presented?
- If so, is this because data are not being generated or captured at all by the health system, or because they are being withheld by the relevant agency/stakeholder?
- Are there any noteworthy trends in the data? E.g. price increases or decreases over time? Issues with the quality of particular types of product? Challenges that consistently affect specific geographic areas, or particular types of healthcare provider?

- Any significant outliers? E.g. unusual gaps in availability? Price spikes? Quality issues with specific manufacturers?
- Do the data indicate bottlenecks or weaknesses at a particular level of the supply chain? E.g. are stock levels good in central or regional warehouses, but poor at facility level?
- Why might such bottlenecks or weaknesses exist? E.g. are distribution problems contributing to stock-outs? Could products be being stolen or diverted?

The major benefit of working as a multi-stakeholder group is the ability to focus on seeking joint solutions: areas where different stakeholders in the pharmaceutical sector can – and in some cases must – work together to ensure improved access to medicines.

Multi-stakeholder discussions might work to develop a combination of short-term and medium-term solutions to identified challenges. They might also consider the longer-term outcomes that might reasonably be expected if these solutions work. This could include the identification of milestones for improvement – i.e. what changes in policy and practice would stakeholders like to see, and how might these changes be reflected in data on price, availability, quality and promotion/use? What is a realistic pace of change, and which indicators would best demonstrate this?

#### Tools:

- The [MeTA Pharmaceutical Sector Scan](#) (developed for MeTA by Harvard Medical School) gives contextual information to aid data interpretation. The Scan is generally carried out as part of the MeTA baseline assessment, as noted above.
- Some useful tools to support multi-stakeholder discussion of data can be found on the [Multi-Stakeholder Process \(MSP\) Resource Portal](#) developed by Wageningen University. The [tools](#) related to ‘organizing and ranking ideas, factors, issues’ may be particularly useful when collectively analysing medicines data. The ‘[issue analysis](#)’ tool helps groups process qualitative data; and the ‘[SWOT analysis](#)’ tool can be useful when comparing new quantitative data against a baseline.

#### *7) Data disclosure and use*

[Focus: use of data and related analysis by stakeholders to change policy and practice.](#)

One of the major benefits of moving towards the routine disclosure of key medicines data under MeTA is that more information is made available to citizens and stakeholders in the health sector, not just those who sit round the table at MeTA multi-stakeholder group meetings.

But for data to be used by others in this way, it is vital that they are presented in a format that is accessible and user-friendly. Again, the development and use of a

simple reporting template – e.g. a set of basic tables – for core data can be valuable here. Other helpful information dissemination formats include posters, leaflets, factsheets, policy briefings and newsletters. These can be used both as hard copy and electronic media and can easily be featured on local MeTA websites. The key is to keep the target audience(s) in mind and to use the presentation format that is most appropriate to their needs.

Indeed, MeTA websites are a key vehicle for disseminating data and for offering some brief interpretation and analysis. Publicly accessible national websites have been developed by [MeTA Ghana](#), [MeTA Kyrgyzstan](#), [MeTA Peru](#), [MeTA Philippines](#) (which is a particularly good example of a website with broad content and data coverage), and [MeTA Zambia](#). The [MeTA International website](#) contains data on [Jordan](#) and [Uganda](#).

**Additional examples of MeTA country information dissemination activities include:**

- MeTA Ghana CSO group posters informed by trends seen in MeTA data;
- MeTA Uganda CSO newsletter;
- MeTA Zambia parliamentary debate, community sensitization activities, radio programme and documentary;
- MeTA Peru documentary (in Spanish – accessible from MeTA Peru [website](#)) and [videos](#) from national MeTA Forums; email newsflashes via listserv and a [Twitter feed](#);
- MeTA Philippines [summary note](#) of the Pharmaceutical Sector Scan;
- MeTA Jordan newsletter (in Arabic); baseline data presentation at a national MeTA Forum;
- MeTA Kyrgyzstan helped to set up a (Russian) [website](#) with all pharmaceutical information in the country. ([English translation of the website](#))

Again, there will be a difference between the formats that are most suitable for disseminating quantitative and qualitative data, as well as a difference between what might be made available on a stakeholder's own website and in their reports, and what might be proactively disseminated by MeTA. Discussions with the media about what data reveal are often best conducted jointly (for example, via a press conference or briefing involving the key MeTA stakeholders and the MeTA Secretariat and/or CSO Group). It is important that the MeTA Secretariat and Council discuss and agree what is most appropriate locally, with a bias towards making as much useful information available as possible and towards encouraging maximum public discussion and debate.

**Example: Promotion of policy dialogue by engaging Parliamentarians in Zambia**

It has been recognized for some time that stock-outs, over-stocking/under-supply, the poor quality of essential medicines, and shortages of paediatric formulations are major challenges being faced by patients and healthcare providers in Zambia. MeTA Zambia used reports on these issues as an entry point for policy dialogue, and mobilized cross-party parliamentarians (including a Cabinet minister) for de-briefing on MeTA core principles, and more importantly on the role of government in improving transparency and accountability within the pharmaceutical sector.

The de-brief generated a lot of interest among MPs who were not aware of MeTA in Zambia and were happy to be consulted. They raised issues concerning medicines affecting their constituencies. They agreed that the issues highlighted by MeTA affected all of them and should thus not be politicized. They pledged to support the initiative.

The MPs later moved a motion in Parliament in April 2010, which provoked excellent live debate in the House, as MPs highlighted the prevailing situations in their constituencies that adversely affected medicines access, availability, pricing and quality. Understanding of these issues was strengthened – and MeTA is now on their radar.

It may even be possible to develop publicly accessible databases, so that medicines data can be searched and manipulated directly by stakeholders – perhaps particularly civil society organisations, the media and researchers – and the public. The Peruvian Medicines Price Observatory, outlined below, is one such example that was generated through MeTA data analysis and multi-stakeholder discussion.

#### **Example: the Medicines Price Observatory in Peru**

In early 2010, the Peruvian government launched a [Medicines Price Observatory](#) – a database of medicines prices at different healthcare facilities across the country, which the public can access through the internet. It is anticipated that this will increase transparency around medicines pricing and that this will improve consistency of pricing across the country.

Drawing on the somewhat limited data available at the time, MeTA Peru identified the need for a Price Observatory during the process of developing its national MeTA workplan. Since then, MeTA Peru has worked with a wide range of stakeholders to build support for the Observatory and to secure its launch. This means that, in due course, the database may hold information from both the public and private sectors. All stakeholders recognize that [developing and populating the Observatory](#) is a long-term endeavour, but they are motivated by the anticipated benefits to consumers and policy-makers alike.

An important ongoing role of each national MeTA Secretariat is in the continued interpretation and communication of data, and in commissioning any follow-up analyses (e.g. pharmacoeconomic analyses – on which see [ISPOR](#) for guidance).

#### Tools:

- There are some good examples of how discussions on medicines policy and regulatory issues have been informed by medicines data in the [WHO Policy Perspectives on Medicines](#) series and the forthcoming HAI Pharmaceutical Policy Briefs.
- MeTA Kyrgyzstan also drafted an informative [case study](#) about a pharmaceutical tender exercise, on which the limited available data showed some irregularities. Stakeholder discussions about this process resulted in civil society organizations being mandated to serve in a procurement ‘watchdog’

role.

## 8) Reporting and monitoring

Focus: monitoring change over time through ongoing analysis and reporting on this to stakeholders and the public

It is important that MeTA Councils and Secretariats monitor and report publicly on trends in data over time. This is vital to informing policy and practice, and also to enhancing accountability – between different stakeholders in the health sector and to patients and the public.

In addition to regular dissemination of data and other information via MeTA websites and publications such as those covered above, MeTA Secretariats should prepare an appropriate annual report for their MeTA Council to sign off prior to publication and dissemination.

For example, a national MeTA annual report might include the following sections, in addition to an executive summary and introduction:

- Summary of MeTA principles and approach
- Summary of national MeTA activities during reporting period
- Outline (or recap) of the national baseline
- Core data from reporting period
- Comparison against baseline; trends over time
- What do data tell us about pharmaceutical sector performance?
- Implications and/or recommendations for policy and practice

Obviously, the compilation of such reports relies on MeTA countries having progressed through the 7 phases outlined above, and specifically on the identification of indicators that can help measure improvements in medicines quality, pricing, availability and promotion/use. These output level data will also help MeTA countries report on whether they are meeting the initiative's purpose and goal.

Note, therefore, that the baseline assessment undertaken initially provides the benchmark for all monitoring at output and purpose level, in both the short-to-medium and longer term.

However, each annual report in effect provides a new benchmark. The cycle should continue, hopefully with each annual report showing progress being made in data availability, supply chain transparency and mutual accountability between stakeholders as well as accountability to patients and citizens specifically. The contribution of this to increasing access to medicines should also be assessed and tracked over time – using data on medicines quality, pricing, availability, promotion and use – and a status report against this goal-level objective should be given in each annual report.

However, it should be noted that undertaking measurement at goal level – which

relates to broader improvements in access to medicines and health outcomes – is not the *direct* responsibility of MeTA Secretariats, but of the relevant stakeholder agencies.

#### Tools:

- Chapter 14 of the WHO/HAI survey manual ([Measuring medicine prices, availability, affordability and price components](#)) gives some advice on how to monitor medicine prices, as well as a detailed case study from Malaysia.
- The [Stop Stock-outs](#) campaign has been supporting civil society organizations in several countries – including two MeTA pilot countries, Zambia and Uganda – to monitor and report on medicines availability in health facilities. MeTA Uganda drafted a [case study](#) on their experience with the campaign and how it has affected ongoing policy debate (including at Presidential level).

### **Using the phased approach in practice**

The approach outlined in this note is flexible enough to be relevant to all MeTA countries, but its use will inevitably need to account for country context. Some of the most relevant contextual determinants are:

- Whether a country has acute needs relating to one or more of the areas covered by MeTA (i.e. price, availability, quality, and promotion/use), which might require some of the steps to be ‘fast-tracked’;
- Strength of routine LMIS system and availability of existing data;
- The structure of the local medicines supply chain and the extent to which this facilitates the collection and sharing of data at different levels of the chain;
- The structure, practices and interrelationship of the three healthcare delivery sectors (public, non-profit, for-profit);
- Council culture, frequency of meetings, role of sub-committees etc.

In practice, MeTA Councils and national Secretariats will need to consider how best to use the MeTA approach and related tools in their own context. There is considerable merit in focusing on areas that are more amenable to change in the first instance. If success can be demonstrated in one area of the supply chain, or in one healthcare delivery sector, or even in relation to a specific set of health commodities, this may facilitate the use of the MeTA approach and tools elsewhere.

### **Securing additional support**

MeTA core partners can assist with provision of technical assistance and other forms of support, to aid you as you move towards strengthening medicines data transparency, joint analysis and the development of evidence-based policies.

For example:

- The World Health Organization can assist with: generating and analysing pharmaceutical sector data relevant to MeTA; supporting countries to carry out pharmaceutical sector facility and household surveys (baseline assessment Component 2); mapping and in-depth analysis of the supply chain; assessment of transparency in the pharmaceutical sector (GGM); assessment

of national Medicines Regulatory Authorities; assessment and monitoring of availability and prices. WHO can also assist with policy formulation and sharing of best practice. Consult the [WHO website](#) or contact Gilles Forte [forteg@who.int](mailto:forteg@who.int)

- The World Bank can assist with financing and technical assistance (as part of World Bank health sector projects in a given country). Contact: Andreas Seiter [aseiter@worldbank.org](mailto:aseiter@worldbank.org)
- Health Action International can assist with medicines price surveys, data collection and the policy implications of data analysis; the regulation and impact of pharmaceutical promotion; democratization, transparency and conflicts of interest. Contact: Tim Reed [Tim@haiglobal.org](mailto:Tim@haiglobal.org)

A range of resources specific to the Medicines Transparency Alliance is available via the [MeTA Toolbox](#).

### **Additional reading and other resources**

The resources listed below have been developed by a wide range of organizations outside MeTA. All relate to information sharing and transparency, although most do not focus on health or medicines specifically. They are offered as additional material to inspire, inform and energise those engaged in MeTA as they work to build transparency and accountability over the long-term.

Videos:

- Sir Tim Berners-Lee, inventor of the World Wide Web, [presenting at TED 2010](#) on the power of data
- Various wonderful TED presentations by demographer and data guru [Hans Rosling](#), including one from 2006 on [how data can bust myths](#) and another on the progression of the [global HIV epidemic](#). He has given many other presentations using his revolutionary Gapminder software – which is freely available to use via [his website](#) – and all are worth a watch.
- Video from [Kenya on how communities have used data](#) to investigate where development funds have gone. (Also available in Spanish and French via the ‘centeronbudget’ channel on YouTube.)

Books and Articles:

- Chan M, Kazatchkine M, Lob-Levyt J, Obaid T, Schweizer J, et al. 2010 [Meeting the Demand for Results and Accountability: A Call for Action on Health Data from Eight Global Health Agencies](#). PLoS Med 7(1): e1000223
- Global Corruption Report 2006, [‘Corruption and Health’](#) (available for download in sections, in English, French and Spanish)
- U4 Brief 2008, [‘Transparency and Accountability in an Electronic Era: the Case of Pharmaceutical Procurement’](#)
- U4 Expert Answer 2009, [‘Approaches to corruption in drug management’](#) (gives MeTA as one example of a promising approach)

Organizational websites:

- [Article 19](#) – website for the global campaign for free expression. Includes a [model freedom of information law](#).
- [Right2Info](#) – fantastic online resource centre focused on the legal and constitutional aspects of the push for freedom of information
- [FreedomInfo](#) – networking site for freedom of information advocates
- Interesting [chronicle of the FOI movement in the Philippines](#), from Action for Economic Reforms.
- [Transparency International](#) – the global coalition against corruption. Their website is full of useful data, reports and campaign materials.
- [Extractive Industries Transparency Initiative](#) (EITI) – similar initiative to MeTA, in the gas, oil and mining sectors
- [Construction Sector Transparency Initiative](#) (COST) – also similar to MeTA, and launched around the same time, but covering construction.